ABORTION LEGISLATION REFORM BILL 2023

Second Reading

Resumed from an earlier stage of the sitting.

MS M.J. HAMMAT (Mirrabooka — Parliamentary Secretary) [3.21 pm]: Before we broke for question time, I was reflecting on the very different attitudes that existed in this house and in our community 25 years ago. It is noteworthy that in the intervening period we have heard the inaugural speech from the member for Rockingham, the thirtieth female member to be elected to this fortieth Parliament. As Madam Speaker just observed, that brings the number of women in this chamber to the majority for the first time ever. It is of interest that at this time, which is such an important historical moment for this chamber, we are debating legislation on abortion, which is a very important issue for women in our community. I was making those comments in the context of acknowledging the work that Hon Cheryl Davenport and others did in progressing the Criminal Code Amendment (Abortion) Bill 1998 through the Parliament 25 years ago. I was acknowledging that our community and the Parliament were different then. As opposition members progressing that legislation, there may have been many occasions that were difficult for them.

In the 25 years since those reforms other Australian jurisdictions have caught up with WA, and in many cases they now provide for more compassionate access to abortion that better reflects contemporary clinical practice. I note that Hon Cheryl Davenport was recently quoted in an article on ABC news online on this reform bill. She was quoted as acknowledging that concessions had to be made in 1998 to get the numbers in Parliament onside to make it possible to pass that legislation. She said —

> "We had to make compromises and they're the compromises that you see today," …

That is indeed an acknowledgement that the circumstances of the time required some compromise in the legislation, so it is entirely appropriate that we come back 25 years later when there are different community standards to address those compromises. At the heart of this bill is the notion that access to abortion is a health issue, and that is a proposition I absolutely agree with. Women should have access to contemporary, safe health care that meets their needs.

I want to also acknowledge the work of our current Minister for Health, Hon Amber-Jade Sanderson, in bringing this bill to the house. She has a strong view on this issue as well, and I really want to acknowledge the way she progressed consultation and consideration of this important issue. She has done it with compassion and a clear focus on meeting the healthcare needs of the women of WA, and I congratulate her for her work.

I looked at the current situation in WA. In 2021, a total of 8 184 induced abortions were notified to the Department of Health. This is according to a document called *Abortion legislation—Proposal for reform Western Australia* dated 18 November 2022, produced by the Department of Health as part of the consultation on the bill. In the 20 years between 2002 and 2022, there was an average of 8 229 notified abortions a year. In fact, the abortion rate per 1 000 women of reproductive age declined in the period from 2002 to 2021. I also want to mention that in 2021, 83 per cent of abortions occurred at a gestational age of less than 10 weeks. Only a tiny proportion of abortions, less than one per cent, have occurred beyond 20 weeks' gestation.

Under the existing legislative framework that will be amended by this bill, under section 199 of the Criminal Code, abortion is lawful in WA as long as it is performed by a medical practitioner in good faith, with reasonable care and skill, and the performance of the abortion is justified under section 334 of the Health (Miscellaneous Provisions) Act 1911. A person who unlawfully performs an abortion is guilty of an offence, with a penalty of up to $50 000. If a person who is not a medical practitioner performs an abortion, that person is guilty of a crime and liable to imprisonment for five years. The Health (Miscellaneous Provisions) Act defines the circumstances under which an abortion can be lawfully performed in WA. The performance of an abortion is only justified if the woman concerned has given informed consent, including receipt of counselling; the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; if there would be a serious danger to the physical or mental health of the woman concerned if the abortion is not performed; or the pregnancy is causing serious danger to the physical or mental health of the woman concerned. In addition to those requirements, if the pregnancy exceeds a gestational period of 20 weeks, the abortion may not be performed by a medical practitioner unless two medical practitioners who are members of a ministerially appointed medical panel have agreed to the abortion, and that abortion must be carried out in a facility that has been approved by the Minister for Health.

There is no uniform way that abortion is dealt with across Australia. It is lawful in all states and territories of Australia to terminate a pregnancy, but the circumstances vary between them. In part the lack of uniformity, but especially some of the unique and restrictive provisions in the WA legislation, have resulted in women travelling outside of Western Australia to obtain an abortion in a jurisdiction where the procedure is more readily available

to access. Obviously, this impacts the health and wellbeing of those women and adds considerable cost and stress to the procedure. Around Australia recent changes to legislative frameworks removed offences from the criminal legislation in each state, recognising quite rightly that abortion is a health issue rather than a criminal one.

I briefly want to talk about some of the provisions this bill will address. I start by looking at the requirement in the current legislation to consult two medical practitioners. The current legislation requires that informed consent be obtained by both the medical practitioner performing the abortion and another medical practitioner, meaning that two practitioners must counsel the pregnant woman prior to the abortion being performed. This is inconsistent with all other arrangements in Australian jurisdictions. It is also inconsistent with the standard of informed consent required for any other medical treatment or procedure in Western Australia. Clearly, there are several problems with this unique requirement. Firstly, it may delay the abortion and bring about additional complexities as a result. Delays in accessing intervention can increase the risk of complications and recovery time and reduce the number of options available. There can be a barrier for some women, particularly in regional or rural areas where there are fewer medical practitioners. Of course, there is additional cost and inconvenience for the woman concerned. I note that changing this provision in the current legislation received overwhelming support from the community during a consultation period conducted by the Department of Health. Over 17 500 people had their say during that four-week consultation period, and on this matter 68.6 per cent supported what was presented as option 2, which was amending provisions to require only one health practitioner to be involved.

I also want to make a few comments about the gestational limit for abortions without the need for additional requirements. In doing that, I want to acknowledge some of the contributions that other members have made in this place. They clearly articulated the challenges that this requirement places on women and their families as they try to navigate the current structure. Under the current legislation, abortions up to 20 weeks' gestation require additional approval. Specifically, two doctors from the ministerial panel must give approval before the pregnant woman accesses an abortion. Those two members of the panel must agree that the pregnant woman or the fetus has a severe medical condition that justifies the procedure, and then the procedure can only be performed in an approved facility.

Late abortions, as they are called, can be extremely complex for both the medical practitioner and the woman involved. That is often because, overwhelmingly, this late in the term of a pregnancy, the woman expects to deliver a full term and healthy baby. As I said earlier, late-term abortions are also incredibly rare. Fewer than one per cent of all abortions in 2021 were considered to be late term. They nearly always arise because of the identification of severe congenital anomalies or conditions that might affect the viability of the fetus. Many assessments for fetal anomalies or other conditions require a pregnancy to have reached a certain gestational stage before they can be diagnosed. Although scans occur at various stages throughout a pregnancy, it is generally accepted that when the 20-week scan is undertaken, it can be seen with sufficient detail to reveal some serious birth anomalies. Obviously, a diagnosis that a fetus has congenital anomalies at this stage is difficult and no doubt shocking for the woman and her family. It naturally takes time for people in those circumstances to work through their options. Further investigation might be required before a diagnosis can be made. Specialists might need to provide advice and recommendations to the woman and her family on what it all means, and then time is often required for the woman and her family to consider their options and reach a decision. For all these reasons, allowing additional gestational time before additional requirements are applied has a number of benefits. It will not only enable more time for a woman and her family to consider their options and choices during what is no doubt a highly distressing period in their lives, but also align WA with other jurisdictions and provide certainty that women can access care here in WA, avoiding the additional expense and difficulty associated with seeking an abortion interstate. It is surprising to learn that women have been travelling interstate to access abortions that they cannot access here. As I said, I have been moved by some of the stories that other members of this place have related in their contributions about the personal impact of that restriction and the kinds of challenges that women have had to endure to access abortions. Not surprisingly, increasing the gestational limit for abortions without additional requirements received strong support from both the community and healthcare providers during the consultation period undertaken by the Department of Health. For that reason, I also support these changes.

This bill also deals with a ministerial panel, which I have already touched on, and the role that it plays. Under the current act, late-term—after 20 weeks—abortion is only authorised when two medical practitioners on the ministerial panel agree that the unborn baby or the pregnant woman has a severe medical condition that warrants the procedure. The ministerial panel is a statutory panel of at least six medical practitioners. No other state uses this model to approve late-term abortions, although they do have additional requirements. I think Victoria, the Northern Territory and Queensland require consultation with another medical practitioner. New South Wales and Tasmania require the involvement of at least one other specialist medical practitioner. Under this bill, the ministerial panel will end. Again, some of the contributions that we have heard from other speakers highlights how difficult many people have found engaging with that panel process to be.

[Member's time extended.]

Ms M.J. HAMMAT: A medical practitioner will be permitted to perform a late-term abortion if they reasonably believe that the abortion is appropriate and they have consulted with another medical practitioner who also reasonably believes it to be appropriate. I also talked about how, under the current act, the Minister for Health has to approve facilities that are able to perform late-term abortions. Currently, only two are approved for this purpose—one in regional WA and another in the Perth metropolitan area. No similar provision in our healthcare system requires the express permission from the Minister for Health for a facility to deliver a particular kind of health care. It is much more usual for the requirements for the safe and effective delivery of the health care to be set out and then for services to meet those standards if they wish to deliver that service rather than have an express provision for the Minister for Health.

I want to say a few other things about the bill and then I will conclude my comments. They relate to the introduction of the provisions relating to the collection, use and management of data. It is important that we collect data. It has an important role in a range of ways relating to how we provision, plan and monitor health services. It also provides an important factual basis for policymakers and legislators. That is particularly important in this area. It enables health research to occur, as well as education and training. In this area, it is equally important that the collection of data not allow for the identification of women who access abortions or the medical practitioners who perform them. It is particularly important in rural and remote areas of WA, which may have fewer women of child-bearing age and, when combined with other demographic characteristics, might make it possible for individuals to be identified. I am pleased to see that this bill strikes the right balance in the collection of data and maintaining that for all the important purposes for which it is used, while also ensuring that it is de-identified to protect the privacy of people who access the service and those who perform it.

In conclusion, I want to acknowledge that I have been contacted by members of the community about this bill. They have been perhaps few in number but many of them hold strong views. I want to acknowledge that is the case on both sides of the debate, if we want to use that terminology. For the record, I want to be clear that I support this bill because I support a woman's right to have control over her reproductive health. I support women having access to appropriate, safe, professional and contemporary medical services. This bill delivers that. It brings WA into line with contemporary standards in other states. For those reasons, I commend this bill to the house.

MS H.M. BEAZLEY (Victoria Park — Parliamentary Secretary) [3.37 pm]: I am proud to rise today to speak in strong support of the Abortion Legislation Reform Bill 2023. It is truly historic legislation. We debate many bills in this place but it is unusual to be able to speak to legislation such as this—legislation that goes straight to human rights, women's rights and what is right.

I wish to take a moment to especially acknowledge former Labor members of our Western Australian Parliament Cheryl Davenport and Diana Warnock, who shepherded through Parliament the original Criminal Code Amendment (Abortion) Bill 1998 upon which we now build, and they did so as opposition members. That is a feat and a legacy by two dedicated, extraordinary women and members of this place—Diana Warnock in the Legislative Assembly and Cheryl Davenport in the Legislative Council; it was a concerted bicameral effort. It is also historic that we are debating this reform after the swearing-in and the inaugural speech of the impressive new member for Rockingham, Magenta Marshall, who has taken the representation in this place to majority female, something I am incredibly happy about and in which I take great pride.

Twenty-five years ago, WA led the way on abortion reform. Now it lags behind. It is somewhat understandable that being in the vanguard of reform in such a fraught area resulted in compromises that needed correcting in time. In the interim, there have also been advancements in medical science and knowledge and the development of a more sensitive and empathetic social stance. These factors can now all be accounted for, and they are in this reform legislation. It is a credit to their foresight that the women who fought for change to begin with predicted such need at the time. Twenty-five years on, it is time to remove the unnecessary barriers to safe termination that remain in the original act while ensuring appropriate safeguards are in place for both fetus and mother. That is what this abortion reform will do. I am here as a proud member of the Cook Labor government, which has done the much-needed hard work to bring this bill to this place, and the proud colleague of the Minister for Health, Hon Amber-Jade Sanderson, who has driven and carried this legislation. I thank the Premier, the Minister for Health, cabinet and my colleagues. I cannot say it enough—this is important.

I will start with the obvious: barriers to abortion services have devastating effects on women. Currently in Western Australia, abortion remains in the Criminal Code. The Criminal Code has no role to play in regulating access to legitimate abortion services, either by women or their doctors. Abortions can be accessed in every other state and territory without risk of criminalisation. This new legislation will remove abortion from the Criminal Code.

Currently in WA, counselling for a patient seeking a termination is mandatory; in every other state and territory, counselling is optional—not mandated. This legislation will make counselling a choice. Participation in counselling should always be the patient's choice.

Currently in WA, a GP referral is required to access an abortion, meaning that the patient has to see two doctors—two doctors who do not object to abortion for religious or other reasons; two doctors who do not cost the earth; and two doctors who have the availability for an appointment within the needed time frame—before an abortion can be undertaken. This caveat particularly impacts women living in regional and remote areas, where a second doctor may be hundreds of kilometres away. There is no equivalent burden in any other type of adult medical care. There is certainly no equivalent in men's reproductive health care, such as accessing a vasectomy. In other words, men have reproductive autonomy—women do not. This legislation will remove the need for a second doctor and allow the patient's chosen doctor to provide continuing care.

Currently in WA, abortion care is not required to be provided by clinicians who object to the procedure on religious or other grounds, even in cases of emergency. In every other state and territory, abortion care is required to be provided in the situation of a medical emergency for the mother. This legislation will rectify this disparity. Medical practitioners may continue to refuse to participate in an abortion for whatever reason, which is completely fair and reasonable, but this bill makes it clear that a refusal does not negate the duty to provide abortion care in an emergency. Currently in WA, the legislative framework does not provide guidance to, or place obligations on, medical practitioners who refuse to participate in abortion care. This legislation will put an onus on a medical practitioner who refuses to participate in an abortion to immediately disclose their objection to the patient and transfer the care of that patient to a registered health practitioner or service that the doctor reasonably believes can provide abortion services or provide information to enable the patient to access treatment elsewhere. That means that under this new legislation, a patient whose GP refuses to participate in their abortion care will no longer have to see several doctors before they find one who is willing and able to provide abortion care, a scenario that costs valuable time and money and raises anxiety and risk to the patient.

Currently in WA, a woman can access an abortion up to 20 weeks' gestation, at which point abortions are approved only by a panel of doctors, who make their decisions with no direct input from the parents, who also have no right of appeal. In every other state and territory, later-term abortions, usually classified between 22 and 24 weeks' gestation, can be performed with the approval of two doctors. Under the new legislation, women will be able to seek a medical or surgical abortion from a medical practitioner up to 23 weeks' gestation, which will be raised from 20 weeks' gestation. After 23 weeks' gestation, a patient will be able to access an abortion when a 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. In other words, two doctors, one of whom is the patient's doctor, will take the full health and wellbeing of the patient and fetus into consideration—not a panel of distant decision-makers.

I will take a moment to talk about late-term abortions. They are incredibly rare. Abortions after 20 weeks' gestation account for less than one per cent of all procedures. Late-term abortions generally involve much-loved and wanted pregnancies and are sought only upon the discovery of a serious fetal anomaly or serious risk to the woman's health. It is almost always a very difficult decision to make and a challenging and life-changing process for families to endure. Patients and families in these situations deserve compassion and care, not judgement or the added burden of dealing with a bureaucracy that has the power to decide the fate of the woman and her family without them being able to provide input.

I have spoken mainly of current barriers to abortion access that do not exist in other Australian states and territories. These are the stark and unfair disparities between Western Australia and the rest of the nation. I spoke about these differences because they add another layer of trauma and confusion for those Western Australian women who seek an abortion, which is either not available to them in WA or is much harder to access—in both cases, it is an inevitably more expensive process—when they can see this necessary care availability and accessibility in other jurisdictions. It feels like a cruel and unusual punishment due to geographic circumstances. These disparities and barriers—there are many others that I have not listed—are what our reform addresses.

Abortion has long been framed as a cultural, religious or personal issue, and rightly so for many reasons, but this framing ignores the other, very real bread-and-butter economic concerns. I have decided to concentrate on this element. I have personal and emotional arguments that strongly support this reform, but those already made by my colleagues, particularly the member for Nedlands, Dr Katrina Stratton, and the member for Hillarys, Caitlin Collins, have expounded those better than I ever could, bringing those of us with a heart in this place to tears—real stories and real effects on individuals' lives and families for whom our current laws do not provide care

or treat compassionately. I thank these members and the many others who made personal contributions for entering a really hard space to do so.

I want to offer a complementary point of support. There is a small but growing body of literature that seeks to determine the causal impact of abortion access on women's economic outcomes, including how educational attainment, labour market characteristics and effects on subsequent generations are directly affected by access to abortion. I think somewhat unwittingly, the United States provided an almost perfect Petri dish for studying that scenario. Prior to the Roe v Wade decision in 1973 that legalised abortion in the United States, five states had already legalised abortion, while several others allowed for it in limited circumstances. In most of that country, however, abortion became widely available only after the 1973 Supreme Court decision. This variation provides two natural experiments—a so-called treatment of legislation in those five initial states and a subsequent treatment when the remaining states changed the legal status after Roe v Wade. This quasi-experiment, combined with econometric analysis, allows researchers to examine historical data to obtain estimates of the causal effects of abortion access. Subsequently, that data was reviewed to provide the highest quality evidence available that synthesises the economic effects of abortion access. The synthesis of that research found that access to abortion allows women to not only better control their fertility, but also, importantly, changes their expectations about childbearing and their control over it. As a result, women invest more heavily in their own human capital, leading to increased schooling and improved labour market outcomes. This is true even for women who have never had an unintended pregnancy. For these women, that is the effect of knowing that abortion care is available to them if needed.

The secondary finding is that these benefits may extend beyond the cohorts of women who initially gained access to abortion to subsequent generations of women and men. In terms of educational attainment, abortion access has been proven to reduce teen fertility and increase women's tertiary education attainment. Studies have proven that access to abortion increased the probability of women graduating from tertiary education by 72 per cent. In terms of labour markets, abortion access has been proven to increase women's participation in the workforce overall. Access to abortion increased women's workforce participation, increasing the probability of a woman working 40 weeks or more a year by almost two percentage points. It also has an effect on earnings. Being able to delay motherhood by one year due to access to legal abortion increased women's wages by 11 per cent on average. Access to abortion expands career opportunities, including the greater likelihood of attaining a professional role by almost 40 percentage points. Access to abortion has economic effects for not only women, but also their children. As abortion reduced the number of unintended births, cohorts of births became more likely to be planned. This improved educational and economic outcomes, both during childhood and later in life. Children born to women with abortion access had lower rates of poverty and receipt of public assistance during childhood, primarily due to a reduction in living with single parents, and they were more likely to graduate college and less likely to be single parents or receive public assistance as adults. Economists agree that abortion access is a matter of not only bodily autonomy and individual agency, but also economic security and opportunity.

In the United States, upon the recent overturning of that pivotal Roe v Wade decision, the United States Secretary of the Treasury, Janet Yellen, noted —

> … that eliminating the right of women to make decisions about when and whether to have children would have very damaging effects on the economy and would set women back decades,"

This direct connection between abortion and reproductive access and economic rights is critical. Abortion access is fundamentally intertwined with economic progress and mobility. As such, unnecessary barriers to accessing abortions constitutes an additional piece in a sustained project of economic subjugation and disempowerment of women. Further, the pattern of connection between medically unnecessary barriers to abortion and negative economic outcomes shows how abortion fits into an economics and politics of control. Prior to our initial reform in 1998, severe abortion restrictions, bans and criminalisation were planks in a policy regime of disempowerment and control over workers' autonomy and livelihoods, just like deliberately low-wage standards or restricted collective bargaining power. More than an echo of that remains, and that is what this legislation seeks to silence.

The Abortion Legislation Reform Bill 2023 empowers on many levels—bodily autonomy, reproductive autonomy, economic mobility, access to opportunity and the ability to decide one's own future. It is about the provision of critical health care to women who have the right to that care, and we have the obligation to provide it. It gives me great pleasure to commend the Abortion Legislation Reform Bill 2023 to the house.

MS R.S. STEPHENS (Albany) [3.51 pm]: I am proud to rise today as a member of Parliament and as a woman to speak in support of a very important piece of legislation, the Abortion Legislation Reform Bill 2023. I know how much this legislation will mean to my constituents, the women of Albany, who rely upon the provision of safe and effective healthcare services. I, like other members in this chamber, have listened with interest to the debate and

the heartbreaking stories shared by many members who have reflected on the personal stories of people in their communities. This bill will help women to access appropriate health care in a timely and effective manner, something that still is not always possible for those living in regional and remote areas. Although Albany is now a bustling and vibrant regional city, it is still 4.5 hours away from Perth by road, and although it has regional airlines, airfares are out of reach for some. The proposed legislative changes will help ease the pathway for women walking what can be a difficult road towards accessing abortion health care. This legislation will not only bring us into line with other Australian jurisdictions, but also provide a more level playing field for regional, remote and country women by removing unnecessary barriers to accessing health care.

We know that the earlier a woman has an abortion, the lower the rate of complications. We also know that many small regional towns have only one doctor at most. Some of these small towns have no doctors, so travel for healthcare services is sometimes necessary. To find one doctor to sign off on an abortion in a small town might be difficult, but to find two practitioners is currently impossible for many. To remove the requirement for two practitioners to be involved in the decision to perform an abortion will immeasurably benefit women living in the country. This amendment alone will remove an unnecessary and unhelpful barrier to their health care.

To expect a woman to receive counselling prior to accessing an abortion is to treat her like a child who cannot make a decision for herself. Women know their bodies, women have agency and women can make our own decisions in our own best interests. Provisions in the Health (Miscellaneous Provisions) Act that require patients to receive counselling in order to be given informed consent to an abortion do not reflect contemporary thinking, practices or expectations. In what other scenario do we demand that patients are counselled prior to accessing legal health care? To require counselling prior to an abortion is an outdated expectation that does not belong in this modern world.

In 2021, when this government removed the right to protest outside abortion clinics, we removed one barrier that prevented women from accessing health care by protecting them from harassment and intimidation within 150 metres of a site offering abortion services. As a consequence, women and girls no longer have to run the gauntlet of abusive activists outside clinics providing abortion services. That was one positive step forward, but I remember the stigma that was attached to abortion when I was younger; in some places, that stigma still exists. I remember how in a country town word got around when a young woman needed to access abortion services. I remember thinking how difficult their experience must be. I remember wondering how a young woman would take those steps if she were not living in the city with access to a range of health practitioners and confidential treatment. How did she do it? She did it with great difficulty and at great expense financially and emotionally. Sometimes, she did not manage to do it. Some women would pass the gestational limit because they lived in a small town, hundreds of kilometres from Perth, and it was too hard for them to find someone to sign off on their decision about their body and their future. The changes proposed in this legislation will go one big step further than the legislation that provided for safe access zones by providing compassionate access to abortion that better reflects contemporary clinical practice. I applaud this legislation as historic, necessary and progressive.

The current legislative framework does not provide guidance to or place obligations on medical practitioners who refuse to provide an abortion due to conscientious objection or otherwise. I am particularly pleased to see this addressed in the Abortion Legislation Reform Bill. Currently, a patient whose general practitioner refuses to perform an abortion, may find that they are required to see several other medical practitioners before they find one who is willing and able to perform an abortion. This is unacceptable. This bill clarifies that both medical practitioners and students may refuse to perform an abortion, but that they must immediately disclose their objection to the patient. The practitioner is then obligated to transfer the patient to a registered health facility that they believe can provide an abortion service or they must provide information to the patient that shows them where to access the approved treatment elsewhere. This process is respectful of the women who seek to have an abortion and provides them with a pathway forward to seek the medical care that they require. If one in five or six women in Australia have an abortion, this legislation will help many thousands of women in Western Australia, and this is what we are here in this place to do—to help people.

I thank the Minister for Health, her department and her staff for their hard work on the Abortion Legislation Reform Bill, and I thank the house for this opportunity to speak about this important bill and to promote it as an essential step forward in health care for women. I applaud this step forward in women's reproductive rights. I thank all the practitioners who have worked under a challenging framework, all the while making sure that women have had access to safe abortion health care. I thank the countless women and dedicated service providers who have had input into the framing of this legislation. Abortion is legal, but it is essential that abortion services are fit for purpose, safe and accessible. Through the consultation process and in the framing of this legislation, the views of all women and all practitioners who had input has been paramount. This legislation will move Western Australia from a position of having restrictive abortion laws regulated under the Criminal Code that took decisions about women's health out of their hands to a position whereby our laws will be fit for purpose and a fundamental part of

the modern woman's health service landscape. It is essential that all women have access to safe abortion services in WA. This legislation will enshrine that right in law. Thank you.

MR W.J. JOHNSTON (Cannington — Minister for Mines and Petroleum) [4.00 pm]: I rise to let the house know that I do not support the Abortion Legislation Reform Bill 2023. I know that many people outside this chamber will not respond positively to me saying that because that happened to me before. However, my conscience is my own. I must say, I do not support criminalising abortion; that idea is without merit. Therefore, the debate is only about the circumstance of the abortion occurring. I also do not accept the idea of the Americanisation of the abortion debate, in which no quarter is given and there is no dialogue nor compromise. I do not agree that compromise is a weakness. I know that I do not get invited to any of the pro-life rallies because I have previously made my views on that clear. I am in a position in which I get criticised by both sides of this debate.

I make it clear that I do not support extremists on either side of this debate. I do not agree that someone who claims to be pro-life can show no love for people who believe they have no other option. I also do not agree with someone who says that they support pro-choice, but refuses to compromise in any way. I also do not believe abortion should be the defining issue of politics. I have personally regularly supported candidates who have supported abortion, and I do not believe that candidates' views on abortion should be the determinative issue about their suitability for public office.

I do not decide for myself on this issue on the question of popularity. I will quote Edmund Burke from 3 November 1774. He stated —

> Your representative owes you, not his industry only, but his judgement; and he betrays you instead of serving you if he sacrifices it to your opinion.

However, I do note that polling in Australia shows that between 20 and 25 per cent of Australians have a generally pro-life position. If translated into this chamber, that would mean that between 10 and 15 members would support my position. Of course, I understand that that will not be the actual result here in the chamber.

It may come as a surprise to some people that the United Nations Universal Declaration of Human Rights does not include access to abortion—it is silent on abortion rights. People can have any political view they want, but should accept that that is their view. It is my view and my own. I also make the point that it is impossible to divorce religious views from any other views that people hold. Of course, our laws are not religious tenets. For Christians, sin can only occur by the exercise of free will. If there is no free will, there is no sin. We are not legislating about sin. However, our laws should consider human rights. Let us just consider some of those. The preamble of the United Nations Universal Declaration of Human Rights begins —

> Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
>
> …
>
> Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person …

Articles 1 and 2 state —

> **Article 1**
>
> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.
>
> **Article 2**
>
> Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind …

It then lists a series of characteristics, including birth or other status. Article 3 is short and to the point; it simply states —

> Everyone has the right to life, liberty and security of person.

Article 5 states —

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6 is also succinct. It states —

> Everyone has the right to recognition everywhere as a person before the law.

Article 7 states —

> All are equal before the law and are entitled without any discrimination to equal protection of the law …

Before I get the comments and abuse that I know I will receive for speaking out against this legislation, I must make it clear that that is from people in the community. I am not talking about our colleagues in the chamber. For the benefit of those critics, I draw attention to articles 18 and 19, which state —

> **Article 18**
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> Everyone has the right to freedom of thought, conscience and religion …
>
> **Article 19**
>
> Everyone has the right to freedom of opinion and expression …

Why am I raising these rights? It is because I cannot understand the logic of a law that will deny these rights to a person who survives a late-term abortion. Whatever political view someone holds, once a person has ceased to be a fetus, there is no debate as to their rights. Indeed, the fact that these laws will remove the obligation of the coroner demonstrates why it is occurring.

As supporters of this bill point out, women who access late-term abortions usually want a child and they access late-term abortions only for medical reasons. Therefore, I do not agree with the logic that a person who comes into life in this way should not be treated with dignity.

I recently read a harrowing account in the *New York Times* of a woman in Florida who was denied access to a late-term abortion in the circumstance that the fetus had grossly misdeveloped. What struck me about her telling of her circumstance was the care she showed towards her intended child. Despite the fact that her fetus could not survive beyond her womb, her care for him was not reduced. Therefore, why is this Parliament deciding that no care is required?

In the end, when discussing late-term abortions, I do not understand why care is dismissed. As we all know, late-term abortions are a very small percentage of all abortions. Personally, I think 20 weeks is the appropriate gestational point to move from abortion on demand to abortion only for medical reasons. This is because at 20 weeks, the fetus has significant capacity. As an example, I will quote from research reported in a publication from the Massachusetts Institute of Technology on 25 May 2022. It states —

> Inside the womb, fetuses can begin to hear some sounds around 20 weeks of gestation.

In research published in PLOS One on 8 June 2015, two researchers stated —

> Although there is data on the spontaneous behavioural repertoire of the fetus, studies on their behavioural responses to external stimulation are scarce.

The study reported responses from 23 fetuses—10 from the second trimester and 13 from the third trimester—using 3D real-time sonography. The conclusion of that research paper stated, in part —

> In summary, the results from this study suggest that fetuses selectively respond to external stimulation earlier than previously reported, fetuses actively regulated their behaviours as a response to the external stimulation …

I urge that the situation of the fetus in late-term abortions should be a focus of the legislation. There are many people who call for the setting aside of religious views in the abortion debate. I am happy for that to occur. Likewise, however unpleasant, people's personal, political and moral views need to be tempered by science. There are many people who call for action to protect many different animals in our community. I do not understand why, despite the science, there is no similar call for care and consideration regarding the operations of late-term abortions. Providing for dignity and reducing suffering for a fetus subject to late-term abortion, to me, is uncontroversial.

In conclusion, I will quickly mention another issue. I will quote Nancy Pelosi on 4 December 2021. Of course, Nancy Pelosi is the former Democratic Speaker of the United States Congress. She is a long-term supporter of women's access to abortion. She stated —

> And it shouldn't be up to any of us to decide what a woman and her family, her husband and her partner decides is right for them and their family …

Abortion should be a choice, but if there is no alternative provided, then it is not a genuine choice. How are we as a community providing a choice if we do not support services that help women who choose not to have an abortion? How are we as a community supporting choice if, for religious or other reasons, people attack women who are pregnant in any particular circumstance? How are we as a community providing a choice if we do not explain the options available to women? How are we as a community providing a choice if we do not make continuing a pregnancy as supported by everyone as accessing abortion?

MR S.J. PRICE (Forrestfield — Deputy Speaker) [4.10 pm]: I take this opportunity to stand and put on the record my support for the Abortion Legislation Reform Bill 2023. I acknowledge the great work of the Minister for Health, her staff and everyone in the department in bringing this piece of legislation to the chamber and the significant amount of work that has gone on behind the bill that we are looking at today.

I am not going to go through a lot of the changes that have already been discussed at length by previous members. I thought about contributing or not contributing to the debate, because, as a male, I do not think I have a role to play in that regard. This piece of legislation is purely about the rights of women, and what they choose to do with their body is their choice; it has nothing to do with me. But I will get to the reason why I am contributing shortly.

The minister stated in her second reading speech —

> The Western Australian community provided its overwhelming support for this government to make important reforms to abortion laws. The bill before us today will place healthcare access and patient experience at the centre of those reforms.

That is exactly what it is all about. It is about access to modern and timely health care for women. We know that a lot of public consultation went on in the development of this bill, as has previously been stated. It was approved by cabinet in September 2022, and there was a four-week consultation period in November 2022, with more than 17 500 people making contributions. Of the respondents, 81 per cent were women. That is a significant amount of consultation. That sort of consultation and support is needed for legislation like this.

As has also been mentioned, this bill will replace the 1998 legislation that was brought in by Cheryl Davenport, an upper house member at the time, with the support of Diana Warnock, the then member for Perth in this place. Back in 1998, it would have been nigh on impossible for the opposition to get legislation through, so it was a fabulous outcome to achieve that. Twenty-five years later, we are looking to remove some of the restrictions that are in place so that it will be a lot easier for women to make the decision to access these services.

Like the members for Bassendean and Churchlands, I am a Catholic. I was brought up a Catholic and went to a Catholic school. One of the reasons I wanted to contribute to the debate is to make it clear that I support the bill. Religion has a role in society; people have different religious views and they act on their religious views differently. What is being debated today is a sensible piece of legislation. It is a sensible reform bill that will benefit the lives of a lot of young women into the future. The member for Victoria Park outlined some of the positive effects of young women having access to abortion services, and all those things need to be taken into consideration when we debate legislation in this place and make the decisions that we make.

Like most members, I have also been contacted by quite a number of constituents who support either side of the argument on this piece of legislation, and to those who have strongly suggested that I should oppose it, I am sorry; I am not doing that. I am letting those people know that I support this legislation. The reasons they gave me are perfectly fine reasons, but in the scheme of representing my community, this is the right decision to make. Once again, getting this legislation through this chamber will certainly be beneficial to a lot of constituents in my electorate.

One of the other reasons I am making this contribution is that I am probably one of the few people in here who have four daughters—no sons, four daughters. This is for them as well. I am extremely fortunate that they are close in age; my oldest is 20 years of age and my triplets are 18 years of age. They have gotten through life fairly well so far, but they have a long way to go. We do not know what the future holds for us, and we do not know people's circumstances and how they might change in the future, but this legislation will provide options for people. I think that is extremely important. To expand on that a little further, there are a lot of females in my family. Of the 15 grandkids, four of whom are my daughters, and great-grandkids, 11 are female. We have a lot of females in the family for some reason. The little family that Mum and Dad started is now up to 27, with nine males and 18 females. There is certainly a lot of oestrogen floating around in my family! To my extended family and all my constituents who will benefit from this in the future, this is a very significant piece of legislation.

Once again, I acknowledge the drive of the minister in bringing this bill through on the back of previous legislation that she has championed through this Parliament and her continued excellent work in this regard. It is something that really needs speedy passage through both houses, and I certainly would like to see that happen. On that note, Acting Speaker, thank you for indulging me and allowing me to put on the record that I fully support this legislation, and I certainly commend it to the house.

MR R.S. LOVE (Moore — Leader of the Opposition) [4.17 pm]: I am going to make a very brief contribution to the debate on the Abortion Legislation Reform Bill 2023. I have listened from my office to a number of the contributions and I have also been in the chamber for some of them, and I thank everyone who has made a contribution to the debate. It is sometimes a very personal experience for people, and I am sure it is a subject

that not only members in this chamber, but also members of the community as a whole have a wide range of opinions and views on.

I think we have had a respectful discussion, and that is important, because these are deeply personal choices for women to make at a time when they are often under a lot of stress. There should never be any consideration of this being anything other than something that involves the health system and it should be treated as a health matter. We know that within the health system and the health profession, there is a deep understanding of the ethics and the ethical framework in dealing with not only abortion, but also areas such as genetics and end-of-life discussions. The medical profession has had a range of very important and deeply significant discussions and developed ethical considerations as a method of addressing these issues over its long history. I think it is wise to leave that great profession to consider and to progress this matter to the point at which it is considered to be fully a matter for the health system, rather than, as we have seen in the past, taking more of a legal approach.

The member for Vasse made a contribution. She has already put on the *Hansard* record that this is a matter of conscience for both our parties; there is no party line in any of these matters. She has some amendments that she will discuss later, and I look forward to that discussion. There will perhaps be other amendments in the other place, and other amendments may be advanced during discussion. In all those matters, I will look to the merits of the argument and make a considered decision on how I cast my vote on those matters as they advance. I thought it important to put on the record that I support the general tenor of this bill, which is to advance this matter into the realm of health care, and to acknowledge that there are many circumstances faced by women who have to make a decision on whether to terminate a pregnancy. I cannot stand in judgement over any of those decisions that they make and I would not wish to.

With that, I conclude my very brief contribution and look forward to further discussion on this bill.

MR P.J. RUNDLE (Roe — Deputy Leader of the Opposition) [4.21 pm]: I also rise to make a brief contribution to the second reading debate on the Abortion Legislation Reform Bill 2023. I recently attended a briefing organised by the Minister for Health, and I thought it was very comprehensive, especially with the panel of doctors who were there. I took on board some of the elements that were brought up. I was very impressed with the way that they handled themselves and the way they spoke about some of the challenging issues.

While the member for Nedlands is here, I congratulate her on her contribution the other day. I thought it was very well done. She outlined some of the traumas that some families and especially mothers and pregnant women go through. The member spoke about the parents of Pippa, the challenges of the 20-week gestation period, and, of course, the extra challenges that that family faced. They had to undertake an amniocentesis. I understand that there is an 11-day or 12-day period in which the cells have to multiply and so forth, so that family was caught in that period between the 20-week limitation and perhaps 22 or 23 weeks. The member spoke about the anonymous ministerial panel, and that struck a chord with me. A panel of faceless people made decisions about a woman's body and her baby's and family's life. The member spoke about how Pippa's family had to travel interstate and the traumas they experienced. Obviously, it was during the period of the COVID pandemic, so they also faced those challenges. Before the member for Nedlands leaves the chamber, I congratulate her on her contribution, which I thought pretty well summarised this bill, quite frankly, and some of the challenges faced by women. As far as I am concerned, as I said to the minister, I am supportive of the bill because it is about a woman having control over her own body. That certainly struck a real chord with me.

The member for Hillarys spoke about the Public Health Amendment (Safe Access Zones) Bill 2020. She, the member for Burns Beach and other members told stories and referred to the situation at Midland Health Campus and so forth. I remember a few years back when we discussed that bill that I found it quite horrifying to think of women who might be going in to have an abortion—I can only imagine the state of mind they might be in—having to run the gauntlet of people intimidating them on the way into the clinic. I certainly took note of the contribution of the member for Hillarys and also the member for Burns Beach, who told a story about one particular case that he dealt with. I am not trying to do the minister's second reading response here!

Ms A. Sanderson: You're doing a good job!

The ACTING SPEAKER: He is!

Mr P.J. RUNDLE: The member for Geraldton also made a good contribution. I was not here for everybody's contribution. From my perspective, it is certainly a very passionate subject. When we asked questions at the briefing the other day about the requirement for two doctors to consider an abortion, I thought that that is especially an issue for our regional constituents. Quite often, there might be only one doctor in the space of 200, 300 or 400 kilometres, so the two-doctor scenario presents a challenge. I was also interested in the discussion about mature minors and the challenges involved with that. One doctor spoke about dealing with teenagers in the clinic that she works in.

I asked her a question about mature minors. I understand the challenges that minors may face when they do not want to tell their parents, and I can only imagine how difficult that might be for not only them, but also perhaps their parents if they found out down the track. I found it interesting to listen to what that doctor had to say on her assessment and how she judges whether a minor is mature. Perhaps the lower age limit might be around 14 or 15 years of age. They are some challenges.

I was certainly very interested in the feedback from the consultation. Option 2 seemed to come forth in pretty much all that feedback as a moderate, sensible option. I am pleased to see that 17 514 responses were received. It is pretty straightforward to me that 68.6 per cent were in favour of having one health practitioner rather than two. It seems common sense that 71.8 per cent of responses were in favour of updated provisions to allow health practitioners to conscientiously object. That will give them that option, because they obviously also have to consider their Hippocratic oath. The provision to increase the gestational age limit was not quite as strongly supported, but was still supported by 60.5 per cent of responses. The responses were also in favour of removing the requirement for a ministerial panel, as I spoke about, whereby a potentially faceless panel makes decisions about a woman's body and life. The requirement for ministerial approval for a health service to perform late-term abortions will be removed. That consultation makes me feel relatively comfortable. As long as sensible measures will be in place, as I said to the minister, I support these reforms. They will bring our legislation into line with the rest of Australia. That is what is happening with this legislation. My final comment is that a woman should have control over her own body. I will leave it there.

MRS J.M.C. STOJKOVSKI (Kingsley — Parliamentary Secretary) [4.30 pm]: I rise to make a contribution to the debate on the Abortion Legislation Reform Bill 2023. As many in this chamber have highlighted, in 1998, WA became the first Australian jurisdiction to decriminalise abortion after Cheryl Davenport introduced a bill into WA's upper house in response to two doctors being charged under the Criminal Code for performing an abortion. The matter of allowing abortions in WA has been decided. The community supported Cheryl and her colleagues then, and now we need to ensure that accessibility and equity for abortion care across our state is realised.

I thought a lot about what my contribution to this debate could be. Anyone who knows me knows that I am a very proud mother of two amazing kids, Nadija, my 13-year-old, and Kristijan, my seven-year-old. At 5.30 the other morning as we jumped in the car to take Nadija to basketball training she saw some notes I had about this bill sitting on the front seat. She asked to read them and I let her. When she was finished, I asked her what she thought. She said to me very simply, "It should be allowed. This is a woman's body; it is her choice." This is the very point we rightly teach our children: that it is their body and their choice. As parents we strive to instil in them body confidence, body positivity, self-respect and agency over their own bodies. Yet, existing legislation, such as the laws we are amending, takes away that choice from them.

I am not a doctor, I am not a healthcare worker, I am not a counsellor or an academic studying in this area, but I am a woman, and like many women, my path to motherhood was not straight or smooth. I had a very wise mentor in Hon Dr Sally Talbot, who told me when I was preparing for my inaugural speech in this place to speak from the heart about what I know, so this is my story.

I have never had an abortion. I was married at 26 years of age and very keen to start a family with my new husband. A medical diagnosis a few years earlier meant that I knew I would have fertility issues and a difficult time conceiving. When I started IVF, I was both hopeful and excited.

The ACTING SPEAKER: Excuse me, member for Kingsley. Ministers, you are quite loud. Thank you.

Mrs J.M.C. STOJKOVSKI: Thank you, Acting Speaker.

I was informed about the process and its potential impact on my body, my mood, my emotions and my mental health. I decided that I wanted to do it. I had my first egg harvest and subsequent transfer. I enjoyed the first of many two-week waits, and then there was the devastating phone call to say, "Sorry, Jess, it has not been successful this time." I was shocked and devastated, but I decided to continue. I am often described as a highly emotional girl. I am a drama queen. I even have a mug that says "drama queen" courtesy of my mother. I wear my heart on my sleeve. I am not apologetic for that. Yet, as an emotional girl, I was allowed to decide to continue—to decide to inject myself daily with hormones and take pills with known side effects such as mood swings, anxiety, depression and weight gain, which, incidentally, did not help with the anxiety or the depression. I was allowed, with the support of my husband who was involved in all of these decisions with me, to spend our hard-earned money on cycle after cycle of IVF to achieve the dream of having a family. After 18 months, two egg harvests, two cancelled cycles because of overstimulation and five egg transfers, we finally had the news that we had been waiting and longing for. I was pregnant with our amazing daughter Nadija. She was everything that we had dreamed of. However, we did not feel that our family was complete, so after 12 months we decided to go back to IVF and try for a second baby.

Memory is a tricky thing. It tells you that things were not that hard, that the dark days were not so dark, and that the mood swings, depression and anxiety were not so intrusive to daily life or impactful to relationships, so the decision was made and back we went. After an additional 13 failed IVF cycles, taking our total attempts to 20 cycles, we decided to move IVF clinics. We engaged another provider to undergo new treatments and procedures such as endometrial scratching, which, let me tell members, is not comfortable. To our delight, four and a half years after our daughter was born, deciding over and over again the course of medical actions we would take, and enduring a further three and a half years of IVF treatment, including undergoing major procedures such dilation and curettage to help with the implantation, I was finally pregnant again. To say we were over the moon is an understatement. Although I was suffering terrible morning sickness, fatigue and terrifying intermittent bleeding, the pregnancy seemed to be progressing well, until my 15-week appointment with my obstetrician, where we were told that our baby girl no longer had a heartbeat. I had had a missed miscarriage. I was beyond devastated. I was heartbroken, and obviously it still affects me today. I was given the choice to wait and to let the body undergo a spontaneous abortion, to get rid of my baby girl myself, or I could undergo a surgical procedure to bring on labour very similar to the procedure of a medical abortion. It is not a pleasant procedure and one I did not enter into lightly, but it was my decision.

After grieving the loss of our daughter, Anastasia Rose, we decided that we would try again—go back and do another cycle. On my twenty-second cycle I found out I was pregnant with my son, Kristijan. Although I had a bumpy pregnancy, we were blessed with our little bundle of joy and energy who makes us smile every single day.

After hearing my story of my IVF journey—an abridged version, not this blow-by-blow account that I have benefited members with—an acquaintance said to me, "After all that, how can you support abortion?" I can proudly stand here today and say that I support abortion because every decision throughout our IVF journey was mine. I owned them. I was given the required information and the choice. I had the right to determine my own health care. Why should any woman in any situation be any different? Why should a woman facing an abortion decision not be given the same care? Is the fundamental reason that I was trying to create life? Is it because our historically male-dominated Parliaments—although I very gladly acknowledge that today we heard the inaugural speech of the newest member of this Parliament, taking our Parliament to a majority of women—were raised with religious beliefs that put a select section of personal beliefs over the rights of a woman to choose her own health care or determine the course of her own life? I could not in good conscience stand here and say that somebody's religious beliefs are more important than the health care or the reproductive rights of thousands of women in Western Australia. I teach both my children to look after, be proud of and respect their bodies, and that they are the ones in charge of them. How can I tell them those things on the one hand and then tell only my daughter, "If you ever find yourself requiring a late-term abortion, a panel of people that you do not know, appointed by a person you've never met, gets to decide for you"? I will admit, given everything I went through to get pregnant and stay pregnant, that I personally do not know whether I could make the decision to have an abortion. I understand how deeply feelings are held, especially for those with religious convictions, about the sanctity of life. I was brought up a Catholic. I understand the teachings. However, I do not believe that any one religion should be able to dictate the rules and laws for an entire society.

We are elected to represent our entire electorates, not specific sections of our electorates. The consultation results demonstrate the support for the changes in this bill. With 17 500 people having made contributions, and 69 per cent agreeing with the reduction of the number of health practitioners required to be involved from two to one and 67 per cent supporting abolishing the ministerial panel requirement for late-term abortions, how could we not listen to those voices?

A woman's GP is a special person in her life. There is a lot of trust and uncomfortable moments in that office. Reducing the requirement to have one rather than two healthcare practitioners not only puts the woman at the centre of her own decision-making in most cases, but also ensures that it can be done sensitively with a trusted person who understands the context of the woman and any medical conditions. It also provides for greater accessibility for those living in the remote and regional areas of our vast state. Importantly, I feel the most important part of this bill is the removal of the ministerial panel. This reflects our modern expectations of a woman's right to choose to be the decision-maker of her own destiny.

MS C.M. ROWE (Belmont) [4.42 pm]: As a proud pro-choice woman, I rise today to also contribute to the Abortion Legislation Amendment Bill 2023. Historically, women right across the globe have always had to fight tooth and nail for their rights—rights that most men are furnished with at birth. Even when we obtain rights that are hard fought for, it is often the conservative agendas or, more often and more specifically, conservative men who try to rescind these rights at every turn. The overturning of Roe v Wade in the United States last year reminded women across the globe that we must forever remain vigilant and alert to agendas that seek to strip back all our rights.

Let us take a brief look around the globe to paint a picture, if you will, and the context within which we see this bill today, and look at how our rights as women are tracking. It is important to look at where we sit from a global perspective to highlight why this bill is so important for all of us here today.

When we debate bills such as the one before us, it is never simply about considering abortion. This bill is related to a powerful and global effort to diminish the role of women and girls in society, which seeks to limit their role to the kitchen and the bedroom.

In an ABC news article dated 31 December last year, Simone Clarke, the chief executive of UN Women Australia, said —

> "We've had some real challenges and, with a lot of indicators, we're actually going backwards both globally and in Australia" …

The same article reports that Amnesty International released a statement warning that events in 2021 and in the early months of 2022 had conspired—I quote Simone Clarke directly—"to crush the rights and dignity of millions of women and girls".

Since the Taliban took control of Afghanistan in August two years ago, it has systematically stripped away the rights of women and girls such that beauty salons and parlours have been shut down, girls have been banned from attending secondary school and, devastatingly, are excluded from attending universities. Women and girls are also banned from gymnasiums, amusement parks and working for non-government organisations. In short, their whole lives are restricted, controlled and thoroughly repressed. As a very important aside, this is leading to an enormous problem for young women who face serious mental health problems. There has been a huge spike in the number of suicides of young women because their futures look so bleak under the Taliban regime.

In Iran, despite ongoing protests by women since the death of Mahsa Amini whilst in custody over her arrest for wearing her hijab too loosely, the Iranian government and its moral police continue to crack down on women's attire. The government is now raiding businesses and fining them up to three months' income if they are found with female staff or customers without the mandatory headscarf. As we speak, the government is looking to introduce laws that will see women who are not wearing headscarves fined up to 360 million Iranian rials, which is 720 Aussie dollars, and given prison sentences. The same laws also look to strictly segregate the sexes in schools, parks, hospitals and other locations. Health officials have also ordered hospitals and clinics to stop providing services to women whose heads are not covered.

Fifteen hours ago, I read with great concern that the extreme far-right politician, Javier Milei, has received the highest number of votes in Argentina's primary election. Why does this matter? It is because he could be plucked from relative obscurity to being a frontrunner for presidency. He has attacked sex education in schools as a ploy to destroy the "traditional family" and is a climate change denier. He has taken to YouTube to announce his plans to abolish ministries he deems unnecessary and—what a surprise!—he shrieked at the camera, "Ministry of women and gender diversity—out!" Further to this, he is anti-abortion and promises "to protect children's lives from conception" in his campaign program. Currently, women in Argentina can obtain abortions, but if Javier Milei wins the presidential election, they will not be able to depend on these rights. This is an example that women can never relax and be reassured that their rights, once enshrined in law, can be enjoyed in perpetuity. They can be rescinded pretty quickly and at any moment, mostly by men.

According to the United Nations, one in three women will be on the receiving end of gender-based violence in their lifetime. Devastatingly, in Perth last week, a Bedford mother of three was allegedly killed in a case of what was labelled by police at the scene as extreme domestic violence. The news reports stated that Ms Tiffany Woodley, the victim, was discovered by first responders unresponsive with "horrific injuries". Sadly, this occurred fewer than two weeks after Georgia Lyall, a woman living in South Guildford, in my electorate, was murdered by her ex-partner.

The total number of women killed across Australia this year due to domestic violence is 34. This atrocious figure speaks to the bleak situation that we face in our suburbs every day. I say that whilst acknowledging that our incredibly dedicated Minister for the Prevention of Family and Domestic Violence is working tirelessly to try to eradicate this scourge in our community as we speak. But let us be clear that responsibility for the problem lays at the feet of the perpetrators. No woman ever deserves to be harmed and nor should they be blamed for that harm. I want it on the record that I know that our minister is literally flying out tonight to make announcements with her counterparts on tackling the very important issue of family and domestic violence.

I move to the land of the supposedly free, the United States of America, where the situation is no better for women. The US Supreme Court made a ruling last year that ended a constitutional right to abortion for women after nearly 50 years. In the United States, the immediate ramification of the decision to overturn Roe v Wade was that abortion became illegal in 13 states. The signal from the Supreme Court allowed the floodgate of anti-women and anti-rights

hatred to spew across the country, something championed for decades by ultraconservative figures who were not only predominantly male but predominately male with outsized soapboxes. I again refer to the ABC news article from 31 December last year, which is titled "Many women's rights were taken away in 2022, but global feminist solidarity is on the rise", in which the chief executive of UN Women Australia, Simone Clarke, states of the Roe v Wade outcome —

> "When you think of something as fundamental as having control over what happens to your own body, I don't think it gets much closer to the core for women individually than their sexual reproductive health," …

This decision has not only set back productive discussions about reducing barriers to abortion services; it has forced women to engage in traumatic debate so that they can fight for autonomy over their own body.

Turning to the Abortion Legislation Reform Bill 2023 that is before us today, I wish to add my voice to the chorus of support it has already, thankfully, received in this place. The passage of this bill is certainly not dependent upon my support. I absolutely run the risk of repeating much of what my esteemed colleagues have already covered, but I want to support this bill because I support bills that seek to empower women and improve their lives. I am also very aware that I am speaking after the member for Kingsley, who gave a very impassioned and personal contribution. My contribution is not personal, but I am maintaining the rage.

Access to safe and affordable abortion care is a right that should be available to all women in not only Western Australia, but also Australia. We are in the Western Australian Parliament so I will be supporting this bill for Western Australian women. The key elements of the bill include removing the need for women to be referred by a doctor for an abortion, removing the requirement for mandatory counselling, fully decriminalising abortions and compelling doctors who conscientiously object to abortions to refer patients to doctors who offer abortion care. Of course, the bill has not been drafted in a vacuum; rather, it is the product of extensive and fulsome consultation with community members, including those who have had an abortion, and health practitioners who provide abortion care. I want to take a moment to state my congratulations to the Minister for Health for her stewardship of yet another truly significant reform. I acknowledge her work and work of her staff and the department in bringing these reforms to this place.

As we have already heard, abortion has been at the forefront of women's health for many decades. We can look back to 1998 to see the courageous efforts of Hon Cheryl Davenport, who introduced the Criminal Code Amendment (Abortion) Bill 1998. We need to acknowledge her advocacy and hard work. I note that the member for Cannington said that there has been respectful debate in this place, and that is true. I am not sure whether Hon Cheryl Davenport would have been afforded the same respect in 1998. I acknowledge that those who have come before us have had a really tough fight. We have it relatively easy in Australia and Western Australia, and in this Parliament—thankfully. The debate in 1998 marked a pivotal step towards acknowledging the fundamental rights of women to make choices about their own bodies. Since then our state has been on a journey of progress and empathy, notably with the Labor government's introduction of the Public Health Amendment (Safe Access Zones) Act 2021. There is an abortion centre in my electorate, so I was very pleased to see the safe access zone legislation brought in. I heard directly from my constituents who had sought an abortion from that clinic and other clinics, but specifically that one. I will not rehash all the stories that were ventilated during that debate but, needless to say, it was traumatic for those women who had made the very difficult decision to have the procedure when they were shrieked at and called all sorts of heinous names as they entered the centre. I am really proud of our government for moving along a progressive agenda for women's health.

It should be noted that WA has some of the most restrictive abortion laws in the country. Ours is the only state in which abortions are regulated in the Criminal Code. Under the law presently, if a woman requires access to an abortion up to 20 weeks' gestation, she is required to obtain approval from a doctor as well as have compulsory counselling. After 20 weeks' gestation, an abortion can only be accessed due to a severe medical condition of the woman or fetus and agreement must be obtained from two doctors from a ministerial panel. I will come back to that in a moment. This removes all decision-making from a woman and can add significant delays to an already time sensitive situation. WA is the only jurisdiction with such a panel approval process. As a consequence of our outdated abortion laws, women have been forced to travel to other Australian jurisdictions to receive abortion services. Of course, that provides an additional barrier to entry because women have to not only go interstate, but also be able to afford to go interstate if they need to access abortion care. That is so unacceptable in this day and age in this country. I fully welcome all the changes in the bill.

Both patients and clinicians agree that this process can be traumatising for families who are faced with that decision. As other members have highlighted, this adds to what is an already difficult time for those who have a wanted pregnancy. I am very pleased to say that this bill will abolish ministerial panel approval. When I read through the

bill and the notes, I could not get my head around the fact that this panel of six or nine clinicians can decide what a woman does with her body—it is obscene.

One of the critical aspects of the bill is that it will remove the requirement for an abortion to be considered by two medical practitioners for a pregnancy up to 23 weeks' gestation. This will reduce barriers and ensure timely access to abortion care, particularly for women who live in the regions or remote communities around Western Australia. The bill will authorise one medical practitioner to perform an abortion on a patient who is no more than 23 weeks pregnant. The bill cautiously sets out what medical practitioners must take into account when the patient seeks an abortion after 23 weeks' gestation. That includes all relevant medical circumstances as well as the woman's current and future physical, psychological and social circumstances. But let us be clear—I know that other members have covered this at length but it is still worth noting—that a tiny number of women seek late-term abortions. Looking at the figures, I see that less than one per cent of all abortions that occur in Western Australia are after the 20-week mark. Such abortions are very rare and they generally involve wanted pregnancies but follow on from a serious diagnosis of a fetal or maternal health condition. Such abortions are carried out in a hospital setting by trained medical practitioners. I reiterate that these situations are rare and have complex medical considerations. This bill proposes a careful and compassionate process that will respect the gravity of such decisions and ensure that the safety and wellbeing of those involved are not compromised. The decision will not be made by a ministerial panel or copious medical practitioners.

Another major aspect of the bill is that it will remove the requirement for mandatory counselling. Sixty-three per cent of survey respondents—this was part of the huge consultation prior to the introduction of this bill—were in favour of this.

[Member's time extended.]

Ms C.M. ROWE: Removing compulsory consultation will bring us into line with other Australian jurisdictions. It also acknowledges that women are pretty capable of making informed decisions about their bodies and lives, with or without counselling. It would be very unlikely that a woman would make such a decision without furnishing herself with all the facts and carefully considering it before seeking an abortion. Participation in counselling should always be the patient's choice. Mandating counselling has the potential to undermine patient autonomy and individual decision-making. The community and stakeholder consultation process established that there was very strong support for the removal of this requirement. Aside from the fact that it should be the choice of the woman, perhaps this was because counselling information is already routinely provided by practitioners, and our state government already funds pregnancy option counselling in the metropolitan and regional areas.

In my remaining time, I will touch on the important consultation that went on. First, I will talk about the issue of minors that has gained a little attention in the media. I do not want to correct the record, but I think there has been a little bit of scaremongering around that matter. It is a little like late-term pregnancies: a very, very small number of people who require access to abortion are minors, but it is vitally important that avenues are provided for young women to seek access and care in a safe way, especially when they do not have a safe place at home or they cannot confide in a family member or guardian.

Provisions are currently in place for girls under 16 years to access an abortion. It is allowable if there is parental involvement, but there is also the process of an application through the Children's Court if parents are not involved. If she seeks an application through the court, a girl can already access an abortion without her parents' involvement; that is already in place. We are absolutely leaving that in place because it is important. We heard from the member for Burns Beach about a terrible situation in which a young girl, a minor, had taken her life because she was pregnant and was so terrified about confiding in her parent or guardian. I never want to see something like that happen. That is absolutely abhorrent. It is important that we provide for young people. Again, they are a very small minority. The option of applying for access to abortion care through the court remains.

A second option will be available if it is determined that a young person has sufficient understanding and is empowered to make decisions about her own health. That treats a person as what in legal terms is referred to as a mature minor. This reflects provisions already in medical care right across all different situations and scenarios, not specifically in abortion care. It is important to establish that this is not something that will be new and specific to this bill. Young people will be provided the opportunity to make decisions as a mature minor, not just in cases of abortion, and this opportunity is already provided to them in many situations.

We in this place can have a sensible discussion about the fact that our medical clinicians are well established at assessing somebody's capabilities for decision-making on a daily basis. We heard from the member for Riverton, a medical doctor before coming to Parliament, and his experience doing exactly that. If a young person comes to a medical clinician, and the clinician feels it is necessary, he or she can refer the young person to social workers

and counsellors to provide more wraparound support to that young person, especially if they come to the clinician without parental involvement. Of course, the option remains to seek an application through the court. This approach respects the autonomy and dignity of young women, while still allowing a role for parents and guardians if that option is available and suitable to the parties.

I end with a summary of what came from the consultation process. It is important that we note, for the record, that it was exhaustive consultation. I commend the minister for this because it meant that the bill truly reflects community needs. Approximately 17 500 people made submissions, 81 per cent of whom were women. That is not a small number. To begin with, I highlight a couple of points. I have already touched on how 63 per cent of respondents wanted to see the removal of mandatory counselling. More than 68 per cent of respondents were in favour of amending provisions to allow only one health practitioner to be involved, rather than two, and more than 71 per cent of respondents were in favour of allowing health practitioners to conscientiously object, with clear and very unambiguous directions to refer patients to another health practitioner willing to provide abortion care. Essentially, this will prevent the situation women can presently find themselves in when they get led down the garden path, strung along by medical practitioners who do not necessarily come clean about their conscientious objection to abortion. They will have to be clear about that, which is a welcome change. Of respondents, 50 per cent were in favour of increasing the gestational age from 20 weeks to more than 23 weeks; 67 per cent were in favour of an additional medical practitioner being consulted to approve abortions beyond 23 weeks; and 65 per cent were in favour of removing the ministerial approval panel requirement before a health service could perform late-term abortions. This consultation overwhelmingly showed support for reform that embraces fewer barriers to abortion services and greater autonomy for women's health.

This bill clearly supports these views. I am proud to live in a state that supports community-led legislation that focuses on preserving a woman's right to make decisions about her own body and, more importantly, her own future. This bill will be a really great step towards embracing a more compassionate and respectful approach to women's health. The WA community can be assured that the Cook government will continue to listen to its concerns and find ways to reduce any stigmatisation surrounding access to abortion services.

I appreciate that the Minister for Health has listened to the views of Western Australian women, and this has been central in developing a meaningful bill that will empower women to make their own choices about their health and wellbeing. Women's right to choose should be a fundamental right afforded to them, no matter where they live. Our rights are always fought for, and we need to be constantly vigilant in protecting them. I am proud of the minister for bringing this important bill to this place, and I absolutely commend the bill to the house.

MS A. SANDERSON (Morley — Minister for Health) [5.07 pm] — in reply: I rise to conclude the second reading debate on the Abortion Legislation Reform Bill 2023. I begin by thanking members for their contributions. The leaders and members on both sides of the chamber have conducted themselves in a respectful and compassionate manner. I particularly acknowledge members who have shared their personal experiences with abortion and the experiences of constituents.

Abortion care is a critical health service and something that every woman should be able to access without being subjected to barriers that do not exist for other health care. Access to safe, legal abortion is a matter of human rights. Many members support my view that every woman should have autonomy over her own body, self-determination over her reproductive rights and the right to decide what medical services she does and does not receive.

Unwanted pregnancies place medical, psychological, emotional and financial burdens on women. In younger women, they may hinder future education and employment opportunities. Making abortion illegal and restrictive has never stopped it or reduced it. It is essential that we, as leaders of this state, work to destigmatise legal abortions and enable better access to the service for all women.

This bill aims to increase access to a fundamental health service. A number of members commented about the difficulty surrounding reproductive services in regional areas. As the member for Kimberley articulated so passionately, this bill will help improve access to abortion care for those in our regional, remote and rural communities. The legislated ability for registered health practitioners, such as nurse practitioners and endorsed midwives, to prescribe abortion medication will go some way to improve access. Nurse practitioners and endorsed midwives are highly-trained skilled health workers who already prescribe a range of medication. This provision reflects changes made at the commonwealth level by the Therapeutic Goods Administration that will allow health practitioners to prescribe this medication.

The bill supports a much-needed new model of care for adults without decision-making capacity. As the member for Bateman noted, the current inability for persons without decision-making capacity to access abortion is not something that should go unchecked in today's society. We do not withhold other health services to patients who are unable to make medical decisions for themselves. Health services should be available to all people, particularly

when it is in the patient's best interests. This bill will do just that. Through the removal of the informed consent provisions under the Health (Miscellaneous Provisions) Act and making amendments to the Guardianship and Administration Act, as with all medical care, health practitioners will continue to seek informed consent ahead of any treatment as a matter of course. However, the bill will provide a clear pathway for adults without decision-making capacity by removing the explicit informed consent provisions and amending the Guardianship and Administration Act to allow decisions in these circumstances to be referred to the State Administrative Tribunal. This is consistent with the approach taken in all other jurisdictions.

Although most young people will be able to confide in a parent or guardian about their healthcare needs, it is not always safe or possible to do so. I acknowledge that this is a reality for some minors and the bill will provide a pathway for those who need it. As the member for Burns Beach shared with us, the inability for young people to access abortion without parental consent can lead to tragic outcomes. By recognising the well-established concept of Gillick competence—often called the mature minor principle—the bill seeks to clarify the pathways to abortion care services for a young person. The Western Australian health system, and, in fact, the Australian health system, already recognises that some children have the ability to consent to medical procedures and treatments, and that a Gillick competent child has sufficient understanding and intelligence to consent to their own medical treatment. The bill will simply align decision-making relating to abortion to general medical care.

The member for Riverton spoke about his experience of providing care to minors as a general practitioner. He outlined that health practitioners are trained to assess decision-making capacity and exercise that clinical judgement through their practice. The bill allows for two options when a minor is deemed to not be Gillick competent. If they agree to involve a parent or guardian in decision-making, the parent or guardian may consent on their behalf. If it is not possible or desirable to involve a parent or guardian, an application can be made to either the Supreme Court or the Family Court of Western Australia. Health practitioners will remain able to seek advice from other health practitioners when appropriate or refer the young person to appropriate support services such as social work or counselling. Furthermore, mandatory reporting guidelines apply to all doctors, nurses and midwives when there are concerns about the young person's safety.

I thank the member for Nedlands for a thoughtful and moving contribution. The member clearly articulated just how important it is that a woman can make her own decision about whether she chooses to access counselling and acknowledged the additional trauma inflicted by unnecessary non-clinical barriers. The ability to choose is fundamental to any decision-making process for health services. By mandating participation in counselling, we disempower women and their ability to make decisions on their own healthcare needs, and this bill will change that.

The member for North West Central touched on the delivery of counselling and support services in regional WA. I acknowledge that for some women, the decision to have an abortion is straightforward, but for others it may be more complex. The majority of women seeking an abortion may not want or need to access additional support. Ensuring counselling services are available to those who want to access them is a vital component of overall reproductive health access. I am pleased to advise that the state government already funds non-directive pregnancy options counselling that can be accessed free of charge. We are absolutely committed to continuing this service. Regional Western Australians in all locations can access counselling by telehealth. In-person appointments are also offered in major regional centres, including Bunbury, Kalgoorlie and Geraldton.

The member for Dawesville aptly touched on her encounters with women experiencing reproductive coercion through her work as a paramedic and psychologist. Although this bill does not deal with that issue, it is worth noting that it fits with the Restraining Orders Act and such women are afforded the protections of that act. Furthermore, the member's contribution should give members the comfort of knowing that health practitioners are well versed in identifying instances of coercion. A practitioner who is not satisfied that a person is acting voluntarily and/or without coercion is able to liaise with other professionals to determine the case. They may also refer the matter to existing authorities, such as the Western Australia Police Force, if they believe that a patient is being coerced or is otherwise concerned for their safety.

I know that the member for Landsdale raised concerns about the very serious situations of family and domestic violence when the partner of the pregnant woman may cause injury to or loss of a fetus. During the development of this bill, a range of government stakeholders were consulted, including the Office of the Director of Public Prosecutions. The DPP advised that the current mechanisms in the Criminal Code provide appropriate pathways to prosecute such conduct.

The bill will enshrine the right of health practitioners to conscientiously object or otherwise refuse to participate in the steps reasonably related to abortion under the act. The member for Central Wheatbelt outlined that some practitioners with a conscientious objection would prefer not to be required to take any action whatsoever. The bill will require

that a refusing practitioner transfer care or provide approved information to the patients so that they may access the abortion service elsewhere. This provision is modelled on a similar provision in the Voluntary Assisted Dying Act. Under that act, the refusing practitioner does not discharge their duty to the patient by virtue of their refusal. Likewise, this bill not only acknowledges the ethical, moral and professional objections to abortion held by some practitioners, but also recognises the need to facilitate timely and appropriate access for people who request an abortion.

Not all patients will have the thought of looking up a statewide service themselves. Instead, their first action would be to go to their GP or regular practitioner. Surely we should enshrine that the patient is provided with the best care possible. The decision of the patient being well informed is fundamental to the proposed model for abortion in WA. This bill strikes the right balance between a patient's right to information and a practitioner's right to conscientiously object. This is consistent with the Australian Medical Association's position on conscientious objection. I was pleased to hear the member for Vasse state that when providing health services, we should place trust in the medical profession rather than creating prescriptive legislation. The bill is a good example of that and more consistently aligns with how other health services are provided in this state and other jurisdictions.

The bill will remove the current requirement under the Health (Miscellaneous Provisions) Act for earlier abortions to be considered by two medical practitioners. The bill provides that the authorisation of one medical practitioner is required to perform an abortion on a person who is not more than 23 weeks pregnant. This change better reflects the capabilities of medical practitioners and addresses some of the barriers to access faced by people living in regional, rural and remote communities.

A number of members commented on the necessity of access to late-term abortions. All acknowledged that less than one per cent of abortions occur beyond 23 weeks. It is not a decision that a person makes lightly, as it almost always involves a wanted pregnancy. For many, it can be an overwhelmingly difficult decision and the legislation should not add to the trauma that families experience. The removal of the ministerial panel will remove an unnecessary barrier to access. The women in this state should not fear decisions so much that they seek an abortion care service from another jurisdiction. We have heard a number of distressing stories about this happening in WA, including from the member for Nedlands and the member for Hillarys.

The bill reflects a proposed change to the current gestational age limit for additional medical oversight for the abortion of the fetus from 20 weeks to 23 weeks. Comprehensive anatomy ultrasounds occur around 20 weeks. Being able to provide general abortion access up to 23 weeks' gestation will better align WA with other jurisdictions to ensure that fewer patients travel interstate for medical care. This change should provide WA families with time to consider all available options and ensure greater continuity of care in very difficult circumstances.

I particularly thank the member for Riverton for sharing his very personal experience when faced with a devastating diagnosis when his wife was 20 weeks pregnant. Families facing these decisions deserve compassion and support, not judgement. He also clearly articulated why the often-mentioned concept of a failed late-term abortion is a furphy. I recognise that there is a lot of misinformation about what a late-term abortion is. For some, this is borne of genuine misunderstanding; for others, it is a deliberate campaign to evoke fear.

Abortions conducted at later gestational ages are very carefully planned medical procedures provided by highly trained practitioners. The process is similar to an induction, whereby medication is administered to induce contractions. In almost all cases, medication is first administered to the fetus. This means that there can be no signs of life after the procedure. This is done via an ultrasound-guided injection that ensures that the medical practitioner can be certain of the outcome. Although almost all women choose this, a very small number opt out of having this injection. This may be for cultural or religious reasons, and it is their right to do so. Families are counselled on all possible outcomes, including the possibility of a live birth. We must remember that in these circumstances, we are not talking about an otherwise healthy fetus; these are fatal or severely life-limiting diagnoses for which even if there were a live birth, there would be no chance of that neonate being discharged home. Comfort care or palliative care is routinely provided if medically indicated. I note that some people in the community have called for mandatory resuscitation care to be provided in these instances. Depriving a mother and her family of precious last moments with a wanted child by obligating practitioners to provide futile medical care would be a cruel act to inflict after having made an impossible decision.

This bill will enable a primary medical practitioner, should they deem it necessary, to consult with a medical practitioner located outside of Western Australia. It is acknowledged that in the vast majority of cases, the primary practitioner would opt to consult with another practitioner based in WA—for example, a colleague at King Edward Memorial Hospital for Women. Notwithstanding this, there may be circumstances in which it would be appropriate for the primary practitioner to consult with an interstate medical practitioner, such as when a patient has been under the long-term care of an interstate specialist prior to relocating or visiting Western Australia. In addition, regional WA already relies on highly mobile medical practitioners who work across jurisdictions. Legislation should

not impede this. As the member for Vasse rightly said, we should place trust in the medical profession rather than having prescriptive legislation that could prevent them from providing the best possible care.

I further note that the term "doctor shopping" has been raised within and outside this chamber. It is a basic component of the Australian healthcare system that all patients are able to seek a second or further opinion from different practitioners. We do not currently limit the number of practitioners a patient can seek an opinion from for other medical care. It should not be different in this case. The use of the term "doctor shopping" in relation to abortion also seeks to raise questions about the integrity and skill of the practitioners involved in this process. Practitioners must be trusted to do the job within their clinical expertise and the lawful practice of their profession.

The member for Cannington made mention of the Universal Declaration of Human Rights and noted that the right to abortion is not captured in the document. He is correct that this 1948 document does not explicitly refer to abortion; however, the Human Rights Committee has confirmed that denying women access to abortion can amount to violations of the right to privacy and, in certain cases, the right to be free from degrading treatment. It has also been clear that even though states have a right to make laws, measures must not result in violation of the right to life of a pregnant girl or woman or her other rights under the covenant.

Members made comment about the consequences of the overturning of Roe v Wade in the United States of America—namely, that the legality of abortion reverted to a decision of each state rather than federal acceptance. The requirement for states to legitimise abortion aligns with our own situation in Australia. We are very cognisant of this fact, and currently we have a government willing to champion the majority view of the Western Australian community.

The member for Collie–Preston aptly spoke about the importance of staying vigilant. She is entirely correct. There will always be people who will fight to reduce reproductive choices for women or those who will bargain away the rights of women to benefit their own interests.

The overwhelming support from members for this bill is no coincidence, with what is now a majority of women in the Legislative Assembly. When women are elected into these positions, it meaningfully improves the lives of women. The Cook government is steadfast in its belief that the right to safety, privacy, dignity and respect for women accessing health care should be protected by this house.

I commend the bill to the house.

Question put and passed.

Bill read a second time.

[Leave denied to proceed forthwith to third reading.]

Consideration in Detail

Clauses 1 to 7 put and passed.

Clause 8: Part 12C Divisions 1 to 5 inserted —

Ms L. METTAM: As I have raised with the minister, clause 8 is the significant body of the bill. It is about the provision and management of abortion and abortion care services in Western Australia. I am hopeful that I can raise some general questions in debate on clause 8.

Throughout the consultation process, a number of different groups raised a number of concerns. I will start with some of the questions raised by the Australian Christian Lobby. This has also been referred to in a petition. The group lobbied for a ban on gender selection abortions, such as has been adopted in South Australia. I understand that a member in the other house has tabled a petition on this. The group highlighted an SBS report in 2015 that indicated a gender imbalance between boys and girls being born in some ethnic communities in Australia and pointed to gender selection abortions. Has the department looked at this issue? Given that it would be a moral objection, was any consideration given to this proposal?

Ms A. SANDERSON: There is no substantive evidence to suggest that abortions occur due to gender selection. The vast majority of abortions occur before the gender is known. There is certainly no appetite to amend this bill to limit gender selective abortions because there is no evidence of it actually occurring. That kind of provision would essentially force a registered health practitioner to move beyond health practice and try to understand what is going on in someone's mind. It is very rare that someone would divulge to a health practitioner that that is why they are seeking an abortion, and it would be up to the health practitioner to make a reasonable assessment on medical and social grounds that the abortion is required. It would be highly unethical, and probably a breach of their registration and code of conduct, if they were to do it based on those circumstances.

Ms L. METTAM: I think all members in this place would find abhorrent the suggestion that abortion would be undertaken on those grounds, hence the importance of clarifying this matter, which has been raised in public. Further

to that, are there any protections for doctors who refuse to undertake a termination due to sex selective requirements or gender requirements of their patients?

Ms A. SANDERSON: No doctor has to participate in an abortion for any circumstances. They are able to object for any reason, whether conscientious or otherwise, if they do not feel competent to perform it.

I mention in answer to the member's former question that in 2020, the New South Wales Ministry of Health undertook a review of the termination of pregnancy for the purpose of sex selection in New South Wales, which showed that abortions are rarely performed for the sole purpose of sex selection. Between 1 October 2019 and 30 September 2020, it was indicated that around 0.08 per cent of all abortions were for that purpose. However, most of those were actually reporting errors, because they were for pregnancies of less than nine weeks' gestation, when there would be no actual way of telling what the sex is.

Ms L. METTAM: Just to finish on this matter, did the minister look at the legislation or the reasoning around the legislation that was implemented in South Australia? That legislation provides that a health practitioner must not terminate a pregnancy for sex selection. I know that the minister pointed to this, but can she explain her concerns about implementing such legislation here?

Ms A. SANDERSON: That is correct; that proposal was moved as an amendment to the bill. It was a political decision to move an alternative amendment to the one that was moved on the floor. It was a tactical decision to move an amendment that would not have limited access, if you like. It was moved by the then Attorney General Vickie Chapman during the passage of the bill in order to manage an amendment that had come from the floor. I think it is a fairly benign amendment.

Overall, as a principle, it would be highly unusual for any medical practitioner to agree to perform an abortion based on sex selection alone. That would be unethical; it would probably be a breach of their practising standards and code of conduct and they could very well be referred to the regulatory body. There are a range of regulations that manage practitioners, and that is why this legislation does not seek to onerously introduce barriers that would not occur in other healthcare settings.

Ms L. METTAM: I refer to another matter. The minister touched on this in her closing remarks in the second reading debate. There was a suggestion in the petition that the legislation should provide that any baby born alive following a late-term abortion procedure must be provided with the same medical attention or palliative care as would be provided to any baby born prematurely. This provision is in the South Australian legislation under the heading "Care of person born after termination". I understand that answers in parliamentary questions revealed that in Western Australia, between 20 May 1998 and 31 December 2021, 31 babies had shown signs of life after an abortion procedure. Can the minister provide some advice on this matter?

Ms A. SANDERSON: The proposition that is put by the petition is somewhat misleading. It also refers to a failed abortion. There is no such thing as a failed abortion, as such. Essentially, less than one per cent of abortions will occur later than 20 weeks. They are very carefully planned medical events and procedures that are performed in tertiary hospital settings by trained clinicians. It is very similar to an induction whereby medication is provided to induce labour. In almost all cases, the fetus is injected with medication that always stops the fetus' heartbeat. There has never been an instance in Western Australia in which that has failed. The decision to proceed with the birth of a live fetus that is knowingly not going to survive is that of the parents and the mother. It is often for religious or cultural reasons and for the purpose of spending the last few moments of life with their baby in a peaceful and supportive environment. Where it is required, babies are provided comfort and palliative care. There is certainly strong representation from clinicians that the baby does not experience any pain or discomfort—at that stage of pregnancy, it is not possible for them to do so—and they are provided care and comfort. Sending in a team to resuscitate a neonate who is not going to survive and give them the same care as they would for a premature baby who has the ability to survive, with high interventions, intubations and all those sorts of really invasive medical care, would rob those parents of that time with their baby, who is not going to survive.

I think that the representative in the Council corrected the answer. There was a reporting error. The original number that was provided to the Council was 31 babies. It is 28. Those 28 babies were planned for, supported and provided comfort care and were able to spend the last minutes of their lives in their parents' arms.

Ms L. METTAM: It is important to get this on the record, because it is a distressing suggestion for many. I take note that when we liaised with Professor Jan Dickinson, she also underlined the minister's comments that we are largely talking about lethal abnormalities in these cases. Can I just confirm that the number was 28 over that period from 1998 to 2021? The figure of 31 was corrected to 28. Can the minister confirm that in those cases there was a lethal abnormality and the baby naturally passed in a comfort care model?

Ms A. SANDERSON: I confirm that the number was 28 over that period. They were all planned and they were all provided care, comfort care and palliative care when required. There would have been a range of conditions, and the parents would have been very carefully counselled on all of the options, including the possibility of a live birth, albeit for a limited time.

Ms L. METTAM: Has any child survived a termination in Western Australia?

Ms A. SANDERSON: I seek clarification. Does the member mean late-term post-birth or early-term termination?

Ms L. METTAM: I refer to whether any child has survived a late-term abortion.

Ms A. SANDERSON: No, they have not because it is either a planned event and the fetus's heart is stopped before birth or they have life-limiting illness and pass away after birth.

Ms L. METTAM: Another point that was raised was mandatory pain relief when a fetus is aborted after 13 weeks. What is the minister's response to this argument about the need for pain relief for fetuses aborted after 13 weeks?

Ms A. SANDERSON: There is no indication that birth in itself is a painful process for fetuses and that they experience pain. There is a lot of evidence about that. When it is deemed clinically appropriate, the clinician will provide palliative care after birth. There is always a paediatrician there to assess the baby once it is born.

Ms L. METTAM: Is there any evidence that supports this theory?

Ms A. SANDERSON: In answer to the member, it is not practice to provide any pain relief to babies after birth, even at 14 weeks. It is not considered a painful process for them.

Ms L. METTAM: I refer to the petition that asked that the safety, privacy and dignity of unborn children suspected of having Down syndrome and other disabilities compatible with life be upheld. The Australian Christian Lobby stated that WA health statistics show that in 2022 there were 71 abortions on account of the unborn child being suspected of having Down syndrome. Can the minister advise whether the number of terminations due to suspected Down syndrome has increased over time? Is there any clarification the minister can provide about this?

Ms A. SANDERSON: Over the past five years or so there has perhaps been a very slight increase. I think that is probably largely attributed to improved genetic testing over the years as it constantly improves. There is more awareness of the conditions in a broader spectrum of conditions to be tested for. It is important to note that of the number of terminations of which trisomy 21 was a factor, it was only one factor; the fetus could have been a multitude of other factors or genetic or other conditions. That is just one factor that would have informed a decision for those parents, and many other factors may have been involved in each of those cases. Often, it is not that factor alone.

Ms L. METTAM: Given that people born with Down syndrome can live fruitful lives, did the government consider mandatory referral of these parents to medical specialists, counselling or support to assist with what is a difficult decision? How does it happen when a parent is advised?

Ms A. SANDERSON: I am advised that this condition covers a very broad spectrum, and it is based on people's individual circumstances and diagnoses. We do not propose to introduce mandatory counselling at any stage. If someone, a mother or a couple, is made aware of a particular condition, they are already under the care of a medical practitioner and a specialist who will provide them with all of the options available and all of the information they need to make that decision. Sending people for mandatory counselling is another hurdle and barrier. People are absolutely entitled to seek all the information and support available to them, and they should, but we will not require people to do that.

Ms L. METTAM: I will go to some of the sections within this clause. We are still on clause 8. I refer to proposed section 202MD, "Performance of medical abortion by certain other registered health practitioners at not more than 23 weeks", under division 2, "Performance of abortion by registered health practitioners". The Australian Medical Association expressed concern about the use of the term "health practitioner" in the abortion legislation discussion paper, as it did not outline an evidence-based justification or preceding consideration regarding the expansion to include non-medically trained Australian Health Practitioner Regulation Agency–registered health practitioners. The bill's explanatory memorandum provides little justification for WA becoming the only state in which medical abortion may be performed by someone else other than a medical practitioner. I refer to the part of the EM that states that this bill "will future proof WA's statutory framework" and "facilitate greater access to abortion services for regional, remote and rural WA". My first question is: can the minister outline an evidence-based justification for the consideration regarding the expansion of these regulatory options to include other AHPRA-registered health practitioners?

Ms A. SANDERSON: There are two parts to this. The first is around prescribing. Essentially, this bill acknowledges that the Therapeutic Goods Association—the commonwealth, essentially—provides prescribing rights and sets that scope. Both the pharmaceutical benefits scheme and the TGA have experts who sit on those bodies, have examined

the evidence and concluded that it is safe for AHPRA-registered health practitioners, such as endorsed midwives and nurse practitioners, to prescribe a medical abortion up to nine weeks. That is within their scope of practice. Essentially, our bill does not allow it; it just does not get in the way of that legislation, if you like. It allows the commonwealth to do its job and to provide updated advice on what is appropriate and safe for those practitioners prescribing or the TGA. After nine weeks, it would be considered a surgical abortion and that would be out of the scope of endorsed midwives and nurse practitioners and, therefore, a breach of their regulations. It would then be up to an AHPRA–registered medical practitioner, who would have the appropriate skills and training to perform a surgical abortion, and that is all set out by their scope of practice and their registration.

Ms L. METTAM: Can the minister clarify whether the TGA changes are already in place?

Ms A. SANDERSON: That is correct. They are in place now, from 1 August.

Ms L. METTAM: This month?

Ms A. SANDERSON: Yes.

Ms L. METTAM: How does this framework compare with other states and jurisdictions in relation to that interface between medical practitioner, health practitioner and prescribing practitioner?

Ms A. SANDERSON: If it is okay with the chamber, we will provide that information on the other jurisdictions' frameworks on other health practitioners at the next day's sitting, noting that they all amended or introduced their legislation prior to this change coming into place on 1 August. I want to give the member the right answer on whether other states are seeking to amend their legislation or whether they have the capacity to essentially do that through regulations. I will provide that information on the next day's sitting.

Mr P.J. RUNDLE: Could the minister enlighten us about the mechanics? Let us say someone is coming up towards the nine-week cut-off date and they have a midwife or nurse practitioner whom they have been working with, but it might flow on to 10 or 11 or 12 weeks. Let us say they would like to go on with their midwife, for argument's sake. Can the minister explain the mechanics? Would that be out of line and they would need to go straight on to a fully-fledged medical practitioner exactly at the end of the nine-week period, or is there a lag period?

Ms A. SANDERSON: There is no lag time as such. It is quite prescriptive. As soon as it hits 10 weeks, it will have to be a surgical procedure, so at nine weeks and six days an endorsed midwife or nurse practitioner can prescribe. After that, it is outside their scope of practice for what they are registered to do. They may continue to be involved in the care of that woman and refer to a practitioner who is medically competent to provide that surgical abortion.

Ms L. METTAM: The minister mentioned this endorsed approach whereby the midwife can have that authority up to nine weeks. Will these changes be communicated amongst health practitioners, medical practitioners and prescribing practitioners—amongst the fraternity, if you like?

Ms A. SANDERSON: Part of the implementation plan for this bill will involve communicating to the registered practitioners. The Nursing and Midwifery Office has already been consulted on this bill and is preparing for a range of consultation. The colleges have been actively lobbying for this change. They will also be very involved in communicating with their members.

Ms L. METTAM: The minister said that the colleges have been lobbying for this change. Not to reiterate what she already said, can the minister explain why they had such an interest in ensuring the inclusion of this provision in the bill?

Ms A. SANDERSON: There are a few reasons. The colleges recognise that there is a critical need to access health care in the regions. Nurse practitioners and endorsed midwives already prescribe schedule 4 drugs, and they want to provide as much service as possible within their scope of practice to the women they support. For women in the regions in particular, this provision is important as it will provide access to health care.

Ms L. METTAM: As a regional member and a member of Parliament, like many members who have been to remote regional Australia, I can certainly sympathise with this argument about the challenges of access to care. Does the minister or the department have any evidence to highlight how this has played out as a result or underlined the need for this provision and this change that is supported by the colleges?

Ms A. SANDERSON: In terms of evidence, we have relied on the experience and practice of nurses and midwives in regional communities, particularly the clinical round tables that we held as part of the development of this bill. The Therapeutic Goods Administration and the pharmaceutical benefits scheme would have done their own surveys to gather evidence and carry out consultation on the impact that this could potentially have on women's health care. There may be a range of other changes. There are very few prescribers now because until 1 August, a prescriber had to be registered and go through a range of processes. Only 10 per cent of GPs actually prescribed it. Since

1 August, any medical practitioner can prescribe it. It was opened up to the practitioners who tend to be on the face of women's health care in regional Australia.

Ms L. METTAM: I will ask a question about conscientious objection. Has the minister heard of or is she anticipating any concerns about medical professionals becoming prescribers under these new changes that make access much easier?

Ms A. SANDERSON: The best way to describe it is as a mixed bag. No-one will be forced to prescribe. No practitioner will be forced to be involved in any kind of treatment they do not want to be involved in, for whatever reason. Younger practitioners certainly have a desire to be involved, be more engaged and receive training on this issue. This goes hand in hand with the provision of and training associated with surgical abortions. It certainly has support from GPs wanting easier access to prescribe. The AMA certainly supports GPs being able to prescribe. It will be a slow build. There will not be a rush. As awareness of this issue increases, and certainly women's awareness of this as an option, we will probably see a higher demand from women wanting access.

Ms L. METTAM: How will this approach ensure patient safety at all times for women who are trying to access an abortion?

Ms A. SANDERSON: Nurse practitioners and endorsed midwives are very highly trained; they have extensive training. In order to prescribe this medication, they will have to have additional training around prescribing. Patient safety is at the core of all aspects of their practice. This medication is widely used around the world, with a very well-known side effect profile. It is nine weeks and less. It would have to be an intrauterine pregnancy. A scan would be required to ensure that the egg is in the uterus, not in the fallopian tube, for example. As I said, it would be an intrauterine pregnancy and they would then prescribe. They would also have to take into consideration the patient's personal circumstances. For example, if the patient lived in a remote area, they may need to relocate closer to other services while they took the medication. All those circumstances would be taken into account and all their extensive training would ensure patient safety.

Ms L. METTAM: The AMA also highlighted that providing abortion services requires medical practitioners to ensure the patient has the tools and counselling services to minimise a further unplanned pregnancy and provide appropriate post-abortion contraception and health care. In some instances, this support will address social concerns relating to domestic violence and sexually transmitted diseases. Medical practitioners provide training and experience, and they provide this level of safety. Is the minister confident that health practitioners will be able to provide that same level of support that was recognised as one of the key advantages of ensuring that medical practitioners provide that care? How will health practitioners be able to fulfil that role?

Ms A. SANDERSON: Nurse practitioners and midwives specialise in women's health; that is what they do. It is not just this particular area. They specialise in women's health and work with women as a whole, as a holistic frame of practice. They screen for domestic violence every day and they screen for coercion and sexually transmissible infections. In rural clinics, it is nurses who do the screening. They are very well practiced at managing patients as a whole and understanding all their circumstances. It is not just about contraceptives. The point about long-acting contraceptives is a good one. The federal government has requested that the Therapeutic Goods Administration look at allowing endorsed midwives and nurse practitioners to implant long-acting contraceptives, which would be an appropriate treatment post-medical abortion.

Ms L. METTAM: Again, the Australian Medical Association submission referred to abortion by a prescribing practitioner, and that the practitioner must prescribe in accordance with the TGA-approved product information for that medication. Is that already the case or will that be the case? Was this considered by government?

Ms A. SANDERSON: Every practitioner has to abide by the laws and the regulations under which they operate, including the TGA regulations for prescribing. They are able to prescribe only as is appropriate for that particular medicine and as recommended and approved by the TGA.

Ms L. METTAM: Earlier, we touched on the role of the medical practitioner, health practitioner and prescribing practitioner. I note that the minister will provide some further information about the various jurisdictions. Following the briefing session, a matter was raised with me, and also by a colleague, about getting some clarity around the time frames of responsibility from the health practitioner to the medical practitioner. The minister mentioned that the health practitioner will be endorsed to undertake a medical approach up to nine weeks, and after that it would be a surgical procedure with a medical practitioner. Can the minister provide some clarification on those thresholds? I think we have also touched on this, but how will they be communicated and to what extent will they be enforced, understanding the challenges?

Ms A. SANDERSON: Up to nine weeks—we say nine weeks and six days—a person will have the option for a medical termination. They can use a prescribing practitioner—that is, a registered health practitioner. For

nine weeks and up the primary practitioner will generally be a medical practitioner. They may have a nurse practitioner or nursing staff involved in the care as part of a multidisciplinary team, but the primary practitioner will be a registered medical practitioner. There are varying methods, depending on the gestation of the pregnancy, whether it is just surgery, or whether it is surgery with an induction and medication. The methods used will depend on how far the pregnancy has progressed, but from 10 weeks, the process will always be led by a medical practitioner.

Ms L. METTAM: I know we will deal with this later, but if a health practitioner and not a medical practitioner deals with the abortion after 10 weeks, will they be deemed to be unqualified?

Ms A. SANDERSON: They would not be acting within the scope of their practice so they would be subject to an Australian Health Practitioner Regulation Agency investigation. It is a requirement of registration that they operate within the scope of their practice. It would put their registration at risk.

Ms L. METTAM: We are still dealing with clause 8 and proposed section 202ME. I refer to the specialist skills required to perform an abortion post-23 weeks. I have been advised that abortion after 23 weeks' gestation is a highly specialised procedure that when performed without expertise is dangerous and traumatic. The Australian Medical Association recommended that it should always involve at least one specialist obstetrician and gynaecologist and the bill should be amended to expressly refer to this. Is this something the government has considered; and, if not, why not?

Ms A. SANDERSON: The bill does not have a specialist requirement. It went through extensive consultation and clinical round tables with clinicians who are engaged in this practice. I have to say that it did not come up at the clinical round table that it should be a specialist obstetrician gynaecologist. We went through quite a lot of detail in the process. The AMA was represented and the Royal Australian College of General Practitioners, fetal medicine experts, obstetrician gynaecologists, general practitioners and midwives were all present. That did not come up. The idea of specialty has been floated, and it was a policy decision not to include a specific specialist, because, essentially, and particularly for obstetrician gynaecology, a fetal medicine expert would do a late-term abortion, not an obstetrician gynaecologist. A fetal medicine expert may require access to a different specialty in order to make a decision. If we limit it to that, we would be limiting that medical practitioner. Ultimately, doctors know who they need to consult to get the right information for their patients. There is no other area of health care in which we would specifically limit the kind of specialty that had to be involved in an area of health care, because every individual's circumstances are complex. There is often a multitude of conditions or personal social circumstances that need consideration. It will be up to those highly trained specialists—they would be specialists, essentially, if it involves a post-23-week abortion—to make the decision about the best practitioner. It may be a gynaecologist, an oncologist, a geneticist or a psychiatrist. They could come from a range of specialties. I appreciate that that is the Australian Medical Association's view. It has put that view and I have said that I appreciate the spirit in which it was put, but we will not accept an amendment that requires a specific specialty to be involved in the care in this instance.

Ms L. METTAM: I refer to proposed section 202ME(4)(a) and the amendment that I flagged that I was going to move that is on the notice paper. I have a few questions that arise from concerns raised with me by Professor Jan Dickinson, who works in maternal–fetal medicine, and the AMA that there is no sound clinical justification in permitting the primary practitioner to consult with medical practitioners whose primary place of practice is outside Western Australia. As I stated, this concern was raised by both Professor Jan Dickinson and the AMA. How did the government arrive at the position of requiring the permission of a doctor who does not reside in WA to provide consent?

Ms A. SANDERSON: The legislation does not require them to consult a practitioner in Western Australia. I think I heard the Leader of the Opposition say that. I want to be really clear: it does not require them to consult a practitioner outside of Western Australia; it simply allows them to. The legislation currently is silent. Practitioners take a conservative approach and therefore do not. It has been flagged with me by the ministerial panel that there have been circumstances in which it would have been incredibly helpful in coming to a decision if they had picked up the phone and consulted a practitioner outside Western Australia. This is about not providing unnecessary barriers to health care. When a patient suddenly presents with a multitude of complex conditions, it is about the practitioner knowing the patient and not limiting that doctor from seeking advice outside Western Australia. I acknowledge that the vast majority will talk to a colleague who they know or work closely with, which is absolutely right, but there is no other of area of health care in which we would put a geographical limit on expertise that can be accessed. Geneticists live in New York; indeed, experts live all over the world. Further, as we know, practitioners are also highly mobile and move around. A good example is a woman who lives in East Kimberley who has a specialist or practitioner in Darwin. She may seek to have treatment on country. When I spoke to the professor, she said that that is what they do: they pick up the phone. She said that she had a woman present whose specialist was in Victoria so she picked up the phone. I said that that is exactly right and what this bill will allow practitioners to do—pick up the phone and talk to the doctor. It happens when a woman is visiting or has relocated. Regional Western Australia

relies on that every single day. It would be an absurd proposition for us to say to regional doctors in any area of health care that they can talk to another practitioner only in Western Australia. We are expanding health care and access to specialist care. The AMA has taken an odd position. We have had the discussion. It is completely inconsistent with everything that it does around accessing expertise, which is what this provision will do. It will not require them to do that; it simply will allow them to do so.

Ms L. METTAM: As I stated, Jan Dickinson also raised this concern without prompting. She was not aware that it had been raised by the AMA. It provided an additional statement after the submission. As the minister stated, it is not explicit in the bill. I was incorrect in suggesting that it is a requirement to consult a specialist outside WA—rather, the bill allows for it. The example given during the briefings was of patients in Kununurra who could potentially be sent to Darwin for the procedure—I am talking specifically about late-term abortions—which is a different jurisdiction. That raises the question about the lack of required medical practitioner capacity in WA. I am trying to get to a question! Is it not the case that all late-term abortions after 23 weeks' gestation take place at King Edward Memorial Hospital for Women?

Ms A. SANDERSON: This is about what is best for the patient. It is not always the case that late-term abortions are performed at King Edward; late-term terminations are performed in Broome. It may be the case that the psychiatrist of a woman in Kununurra who has a very complex psychiatric history is located in Darwin, but she might go to Broome to have the late-term termination. Every situation is complex. It is not necessarily about knowing the specialty subject matter; it is about knowing the patient and what is best for the patient. The second practitioner will not perform the abortion; rather, they will advise on the patient and provide advice for the patient. This is not in any way some kind of reflection whatsoever on clinicians in Western Australia. We have some of the best clinicians, many of whom members in this place met during the course of this debate. This is about making sure that they are not limited when they seek the best information for their patients. That may well be on a very rare and specific genetic condition or a psychiatric condition. It might require oncology input. The reality is that not all specialists reside in Western Australia, and people have to go interstate to seek care. People go interstate to seek specialty oncology care. This is not a wild provision. This will not limit doctors.

Ms L. METTAM: I thank the minister for her arguments surrounding the justification for the bill as it is and for not providing an amendment. I understand that the minister has discussed this with the AMA and perhaps with Jan as well. They maintain their concern. They find it confusing, given the context of late-term abortions.

I have two amendments, but I could just move them in a block together. Would I then speak to that? Of course, I seek leave to do that. I have two amendments to clause 8 that I wish to move. The amendments are on the notice paper, and I suggest that I move the two amendments en bloc rather than separately.

The ACTING SPEAKER (Ms A.E. Kent): We will do that first.

Ms L. METTAM — by leave: I move —

> Page 9, line 28 — To delete "(1)(b) —" and substitute —
>
> (1) —
>
> Page 9, lines 31 to 33 — To delete "a medical practitioner with whom the primary practitioner consults need not" and substitute —
>
> the primary practitioner, and of a medical practitioner with whom the primary practitioner consults, must

I was going to speak to it, but I have not done this before. This is my first time moving an amendment. As I stated, the feedback I had was that there was not a sound clinical justification for the medical practitioner with whom the primary practitioner consults, for the purpose of this clause, to have a principal place of practice outside Western Australia. I have asked the minister some questions about that. We are talking about late-term abortions—a very specific procedure. The large majority of cases are overwhelmingly at King Edward Memorial Hospital and occasionally at Broome Hospital. As a member of Parliament, I can only consider these matters and take into account the clinical advice I have received. The submission stated —

- ensuring two doctors who are familiar with the patient, WA's health system and capabilities, will be able to advise and support the safest and most appropriate provision of post 23-week gestation abortion healthcare; and
- **does not prevent** those WA doctors' seeking the opinion of any other health professional (either interstate or overseas) involved in the delivery of care to the patient and whose opinion may support determining whether an abortion is appropriate, which may in fact be required by virtue of optimal patient care.

I will leave my comments there and look forward to the response.

Ms A. SANDERSON: The government will not be supporting the amendment, for a range of reasons. Essentially, it was not outlined by the AMA in the member's moving of the amendment. I appreciate the spirit in which the member is engaging with the debate, but we will not be supporting this amendment.

It is completely contradictory to say that this would not limit them from seeking advice interstate. Essentially, it would require three practitioners: two in Western Australia and one interstate, if required, which is completely unnecessary. If we did a straw poll of whether doctors thought it was reasonable to limit their ability to seek expert advice in any area of healthcare provision to the jurisdiction of Western Australia, they would say, "No, it is not reasonable". Why would they seek to do it for women? Why would they seek to limit this advice for the provision of health care for women? That is what this is: it is the provision of health care for women alone. There is no area of health care in which we would say to a practitioner that they can consult only this specialist in this geographical area. There is no other area; it goes completely against the principles of good medical practice and patient-centred care. Ultimately, this bill is putting women at the centre of abortion care and at the centre of what they need and what is best for them. They might need access to their psychiatrist who lives in Queensland. They might need access to their oncologist who lives in Victoria. They might be visiting from the Northern Territory and land in Broome, seeking expert care, and this amendment would limit the doctors to whom the primary practitioner could go.

It is totally a contradiction to most things the AMA stands for: valuing the qualifications of doctors; valuing the decisions of the primary practitioner, who knows what is best for the patient; and valuing the skills and expertise of the doctor to know whom they need to talk to. It might be a geneticist who lives in London or who lives in New York.

We are not supporting the amendment. This would unnecessarily limit practitioners and would interfere in the important relationship between doctor and patient. That is what this is; it is about the relationship between the doctor and the patient and them determining the patient's health care.

Scenarios have been provided through the ministerial panel in which it would have been incredibly helpful to have an interstate practitioner. I respectfully disagree that this is required for safety. Doctors all have to be very mindful of their code of conduct, Australian Health Practitioner Regulation Agency registration and the codes they have to operate under as practitioners. In 99.9 per cent of cases, practitioners have a lot of integrity and care for their patients. I think it is inappropriate to limit it for women and women's health care so that they can only seek certain specialists within a particular geographical location. We have heard from the member for Riverton, who is a practising doctor, that he does not support it, and I think the member would struggle to find any medical practitioners who would support the principle of being limited by geographical location alone.

Division

Amendments put and a division taken, the Acting Speaker (Ms A.E. Kent) casting her vote with the noes, with the following result —

Ayes (6)

Ms M.J. Davies	Mr R.S. Love	Mr P.J. Rundle
Dr D.J. Honey	Ms L. Mettam	Ms M. Beard *(Teller)*

Noes (44)

Mr G. Baker	Ms M.J. Hammat	Ms S.F. McGurk	Ms A. Sanderson
Ms L.L. Baker	Ms J.L. Hanns	Mr D.R. Michael	Ms J.J. Shaw
Ms H.M. Beazley	Mr T.J. Healy	Mr K.J.J. Michel	Ms R.S. Stephens
Dr A.D. Buti	Mr M. Hughes	Mr S.A. Millman	Mrs J.M.C. Stojkovski
Mr J.N. Carey	Mr H.T. Jones	Mr Y. Mubarakai	Dr K. Stratton
Mrs R.M.J. Clarke	Mr D.J. Kelly	Mrs L.M. O'Malley	Mr C.J. Tallentire
Ms C.M. Collins	Ms E.J. Kelsbie	Mr P. Papalia	Mr D.A. Templeman
Ms L. Dalton	Ms A.E. Kent	Mr S.J. Price	Mr P.C. Tinley
Ms D.G. D'Anna	Dr J. Krishnan	Mr D.T. Punch	Ms C.M. Tonkin
Mr M.J. Folkard	Mr P. Lilburne	Mr J.R. Quigley	Mr R.R. Whitby
Ms E.L. Hamilton	Mrs M. Marshall	Ms R. Saffioti	Ms C.M. Rowe *(Teller)*

Amendments thus negatived.

Ms L. METTAM: I seek some clarification from the minister. I refer to page 14, proposed section 202MI contained within clause 8. I have raised this matter previously with the minister. A number of doctors have spoken to me at my office about conscientious objection. These doctors were concerned that they might have to be involved in clinical or research activities to which they object. This part of the bill refers to a refusing practitioner. We were advised during consultation that instead of mandating a medical referral, there will be a requirement for conscientious objectors

to provide essential information and advice to patients who seek abortion services. Proposed section 202MI(2)(a) refers to this. Can the minister confirm what the referral obligations will be for a doctor who objects to providing such a service?

Ms A. SANDERSON: The provision in this bill strikes a balance and allows a practitioner to refuse to participate, but not without discharging their obligation to provide important information to the patient. That is consistent with the Australian Medical Association's policy position on conscientious objection that it should never impede access to care. Although it a right for clinicians to conscientiously object or otherwise, it should never impede access to care. It is important to note that there are a range of objections that are not always conscientious. Sometimes a practitioner does not feel skilled or they do not have the information and they are required to object. That is why we have put that provision in there, which is similar to the voluntary assisted dying provision and AMA principles. First, the practitioner will need to declare up-front at the consultation that they object, and then they can take one of two options. They can refer the patient to a clinician who they know will provide care or they can provide a centralised phone number or information that is kept up to date by the Office of the Chief Health Officer that will help those women to access the care that they need. The Chief Health Officer will be required to keep that information up to date. This has been done to avoid a number of scenarios; primarily, women cycling through various doctors and not knowing where to access care, which can prevent the up-front declaration of the objection. This provision requires GPs and clinicians to be up-front about their objection. From evidence gained during the consultation process, we learnt that GPs will go on a journey with a woman, and they will talk about the abortion. They will send them for a scan that might be completely unnecessary. They will send them for bloods and bring them back for a discussion in the hope of possibly changing their mind. That is not to say that all of them do that, but that has certainly occurred for many women, by which time they have past the opportune time for a medical abortion and have gone into surgical termination territory. They have been to several practitioners at great expense and not received the care that they require. It requires practitioners to be up-front about objection for whatever reason, and then either refer to another clinician or provide a phone number that essentially provides them with all the information they need, which will be kept up to date by the Chief Health Officer.

Ms L. METTAM: On the communication with the Chief Health Officer, is there a register for that communication of the information provided and the communication with the medical professional or health professional who may be involved?

Ms A. SANDERSON: A range of resources will be kept by the Chief Health Officer. It will not be every single provider or practitioner, but a range of resources where women could find that information. King Edward already provides similar resources for GPs, and it could be similar to that. Over the next six months, it will be produced by the office of the Chief Health Officer and distributed through its networks to clinicians to ensure they have that information.

Ms L. METTAM: I think I can guess the answer, but can the minister provide a copy of the information that will be provided to patients by an objecting doctor?

Ms A. SANDERSON: It is not yet in existence. It will be developed over the six-month implementation time frame and will be publicly available on the women and newborn service website or the office of the Chief Health Officer website. It will be easily accessible.

Ms L. METTAM: What level of detail can the minister imagine will be provided in this document?

Ms A. SANDERSON: It will be the level of detail that would allow a patient to access a service without hindrance.

Ms L. METTAM: The Australian Christian Lobby is calling for all information, brochures and webpages that provide information about abortion be required to provide the contact details of agencies that can assist women materially, emotionally and financially to enable them to deliver and care for their baby safely. Can the minister respond to that request from the Australian Christian Lobby? Will any consideration be given to providing such information in a brochure about what is available?

Ms A. SANDERSON: Information about free counselling services will be provided but they will be free counselling services that are secular and not steeped in religious bias or seek to steer women in a particular way. They will be genuine counselling options for women as well as information on services that they can access when they have made their own determination.

Ms L. METTAM: To clarify, will secular information be provided to women who may be open to reconsidering an abortion? Will information be provided that will support a woman regardless of which direction she may decide?

Ms A. SANDERSON: The information is about accessing services not requiring people to have counselling. The information will be about access to services. In their consultations, medical practitioners will canvass the option

of counselling and provide that option for women. The state funds free counselling in these circumstances and will continue to do that. In all those consultations in which practitioners talk to women about their options, it would be good practice for them to do that and to provide them information and options.

Ms L. METTAM: The South Australian bill lists providing information first, and then mentions the transfer in care. Was there any consideration of what South Australia provides in its legislation?

Ms A. SANDERSON: The provision around objection—let us just call it objection or objecting to providing care—was canvassed through public consultation and also clinical round tables. It was unanimous around the round tables with the Australian Medical Association, the Royal Australian College of General Practitioners and GPs who practice in this area of primary care that this was the right approach. I took their advice on this, and it is consistent with the AMA's policy position around objections not inhibiting access to care. It is consistent with the voluntary assisted dying provisions around allowing clinicians to object without hindering access to care. That is why we landed at this position.

Ms L. METTAM: The South Australian Termination of Pregnancy Act 2021 includes a provision that a woman must be provided with information on where she can access counselling. Was this considered? I am not talking about mandatory counselling but just information on where it is available. Was this given any consideration?

Ms A. SANDERSON: That is part of an ordinary consultation between a clinician and a woman. We are not going to mandate any particular counselling services or any other provision of information. That is on the best judgement, skill and training of the clinician who knows that patient and who will have the conversation with her about what she needs and where she needs to go.

Ms L. METTAM: Perhaps where this matter of counselling has come up the most in discussions I have had with community members is in relation to children who are undertaking abortion. I again refer to this section on minors and those who are not mature minors. Can the minister talk to this? We have touched on why there is no mandatory counselling, but can the minister explain it? From the briefings I have had with her advisers, I know what the clinical approach is to abortion for children who will undertake abortion with the new provisions in this bill that do not require parental consent or approval from the Children's Court. What provisions are there to satisfy the minister that this change makes the best interest of those children most prominent?

Ms A. SANDERSON: When dealing with a minor, an under-16 who is pregnant, a very sensitive conversation will be had with a health or medical practitioner about whether she needs to involve her parents. It is rare. They routinely make referrals to services, whether it is counselling or social work, for children under 16 years to support that young person. They would probe the circumstances by which this child had become pregnant. If there were safety considerations and reporting requirements, they would take those very seriously.

There will be mandatory reporting requirements and a range of child protection responses that will come into play around younger children and those under 13 years old. Those older Gillick competent minors will potentially be referred to a range of services, but the medical practitioner will make the determination of what service referrals and information would be appropriate for that child.

Ms L. METTAM: The minister touched on the mandatory reporting requirements for medical, health and prescribing practitioners. Can the minister clarify the responsibilities there and for matters that require a report to child protection and how that will be communicated?

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

House adjourned at 7.03 pm