

**Hon Andrew Little**  
Minister of Justice

**Proactive release – Abortion Legislation Bill (Cabinet Papers)**

Date of issue: 21 November 2019

The following documents have been proactively released in accordance with Cabinet Office Circular CO (18) 4.

Some information has been withheld on the basis that it would not, if requested under the Official Information Act 1982 (OIA), be released. Where that is the case, the relevant section of the OIA has been noted and no public interest has been identified that would outweigh the reasons for withholding it.

No.	Document	Comments
1	<b>Taking a Health Approach to the Regulation of Abortion</b> <i>Cabinet Paper</i> Ministry of Justice <i>Meeting date: 22 May 2019</i>	Some information has been withheld in accordance with section 9(2)(g)(i) and (ii) of the OIA to: <ul style="list-style-type: none"><li>• protect the confidentiality of advice tendered by Ministers of the Crown and officials; and</li><li>• protect Ministers, members of organisations, officers, and employees from improper pressure or harassment.</li></ul>
2	<b>Taking a Health Approach to the Regulation of Abortion</b> <i>Social Wellbeing Committee Minute</i> Ministry of Justice <i>Meeting date: 22 May 2019</i>	Some information has been withheld in accordance with section 9(2)(g)(i) and (ii) of the OIA to: <ul style="list-style-type: none"><li>• protect the confidentiality of advice tendered by Ministers of the Crown and officials; and</li><li>• protect Ministers, members of organisations, officers, and employees from improper pressure or harassment.</li></ul>
3.	<b>Abortion Legislation Bill 2019: Approval for Introduction</b> <i>Cabinet Paper</i> Ministry of Justice <i>Meeting date: 23 July 2019</i>	Some information has been withheld in accordance with section 9(2)(g)(ii) of the OIA to: <ul style="list-style-type: none"><li>• protect Ministers, members of organisations, officers, and employees from improper pressure or harassment.</li></ul>
4.	<b>Abortion Legislation Bill: Approval for Introduction</b> <i>Cabinet Legislation Committee Minute</i> Ministry of Justice <i>Meeting date: 23 July 2019</i>	Some information has been withheld in accordance with section 9(2)(g)(ii) of the OIA to: <ul style="list-style-type: none"><li>• protect Ministers, members of organisations, officers, and employees from improper pressure or harassment.</li></ul>

In Confidence

Office of the Minister of Justice

Chair, Cabinet Social Wellbeing Committee

## **Taking a Health Approach to the Regulation of Abortion**

### **Proposal**

1. This paper seeks agreement to draft a bill containing proposals to decriminalise abortion and align the regulation of abortion services in New Zealand with other health services.

### **Executive Summary**

2. In New Zealand, abortion is a crime in the first instance. This attaches a heavy stigma for women considering or obtaining an abortion and for health practitioners giving advice and providing services.
3. The law relating to abortion is over forty years old. The framework for abortion law is set out in the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977.
4. The paper sets out a range of proposals based on the Law Commission's recent briefing paper that gave advice on what a health approach to abortion could look like.
5. The current offence relating to pregnant women who procure unlawful abortions should be repealed. The current offences relating to health practitioners should be repealed. Health practitioners who do not comply with relevant standards or processes for performing an abortion would be sanctioned under the complaints and discipline regime for health practitioners.
6. An offence would be retained in the Crimes Act 1961 for unqualified people who perform abortions. The offence of killing an unborn child will also be retained, with any necessary modifications to ensure that it does not apply to lawful abortion, and that it captures people who assault women causing the death of a fetus.
7. The process to obtain an abortion is complex and bureaucratic. This can delay access to services and be detrimental to the woman's health and wellbeing.
8. I propose that, for pregnancies of up to 20 weeks' gestation, a pregnant woman can make the decision about abortion, in consultation with a suitably qualified health practitioner ensuring that counselling is offered and available.
9. After 20 weeks' gestation, the health practitioner would be required to, having regard to the pregnant woman's physical and mental health and wellbeing, reasonably believe that the abortion is appropriate.

10. Monitoring and regulating abortion services as a health service would enable earlier access to services. Early abortion is safer and less distressing for women and for health practitioners.
11. The right of a health practitioner to object to providing abortion services, and the right of the woman to access the services in a timely way, must be appropriately balanced. I propose that practitioners who object on conscience grounds must disclose their objection to the pregnant woman and refer them to a practitioner who can provide the service.
12. The operational and accountability aspects of the proposed framework would cover access to services, the licensing of premises, ensuring that only suitably qualified, registered health practitioners with a current practising certificate perform abortions, and the oversight of abortion services generally. There would, however, be statutory provisions so women can self-refer to services and to ensure the availability of counselling in a timely manner.
13. Safe access zones aim to protect women accessing abortion services from intimidation by protesters. I propose including a regulation-making power, so that a safe access zone could be implemented to prevent harm to pregnant women or health practitioners accessing a specific facility.
14. No changes are proposed to the current laws around informed consent or parental notification for abortion.
15. No changes are proposed to the laws relating to diminished capacity at this time.

### **Abortion in New Zealand**

16. Although the number of abortions has declined over the last decade, it is a relatively common procedure. In 2017, 13,285 abortions were recorded, that is a rate of 13.7 abortions per 1000 women. In 2007, 18,382 abortions were recorded (at a rate of 20.1 per 1000 women).
17. Most abortions (89.4 per cent in 2017) are carried out in the first trimester of pregnancy. However, first trimester abortions in New Zealand are, on average, carried out later in that trimester than in other developed countries. This is largely attributed to the complex process required under the current law increasing the delay thereby preventing abortions from being performed as early as would otherwise be possible.
18. Early first trimester abortions are generally safer and less distressing for both the woman and the health practitioners involved. Under the current regime, some women are required to wait several weeks to access services. This delay can be traumatic and may have a significant impact on the woman's health and wellbeing.

### **Overview of the Abortion Law Framework**

19. Under the Crimes Act 1961 (Crimes Act) it is an offence to procure, or supply the means to procure, an abortion. These offences are subject to certain exceptions about what is lawful, which are set out in the Crimes Act. The process for accessing abortions is highly prescribed in the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act).

20. The provisions relating to abortion in the Crimes Act and in the CSA Act have not been amended since they were first enacted. This means that our abortion laws are now over 40 years old.
21. I do not consider that abortion should be regulated by our criminal law. It is my view that abortion should be treated as a health issue, and that a woman has the right to choose what happens to her body in consultation with her health practitioner.
22. Our current law is complex and bureaucratic. It requires a pregnant woman to go through multiple steps to obtain an abortion. This can delay access to appropriate health services and be more distressing for the woman and health practitioners.
23. I propose that the regulation of abortion services be broadly aligned with the regulation of other health services. This would enable earlier access to appropriate health services, resulting in better health outcomes. This is because, for women who decide to have an abortion, earlier first trimester abortions are safer.
24. Moving to a health approach is more consistent with our international human rights obligations. International human rights organisations consider abortion to be a matter of sexual and reproductive health that should not be criminalised.

### **Discussion of Proposals**

25. In February 2018, I asked the Law Commission for advice on what treating abortion as a health matter could look like. The Law Commission reported back on 26 October 2018 with its briefing paper *Alternative approaches to abortion law*, which describes changes that could be made to remove the criminal aspects from abortion law and align it with a health approach (Law Commission briefing paper).
26. This section sets out the key proposals to align the regulation of abortion services with other health services, enable earlier access to services, and support the best health and wellbeing outcomes for women.
27. These proposals are based on the options and discussion in the Law Commission briefing paper and my discussions with many of you. I request that Cabinet agree to the drafting of a bill containing the proposals set out in this paper.
28. Other consequential amendments may be required to the Contraception, Sterilisation and Abortion Act 1977 to ensure that the language of the legislation is consistent with taking a health approach to the regulation of abortion.

### ***Removing the criminal basis for abortion***

#### *Current framework*

29. Currently, the starting point for abortion is that it is an offence for both the woman obtaining an abortion and the practitioner carrying it out. A woman seeking an abortion has her actions stigmatised with criminal overtones. It also means she and the practitioner are driven more by procedural compliance than considerations of the woman's health, which should be their primary focus.

### *Proposals*

30. I propose to repeal the offence relating to pregnant women who procure abortions.
31. I propose that a suitably qualified, registered health practitioner with appropriate training and experience, should be able to perform an abortion, or supply products to induce an abortion, as with other health services. Under general health law, these practitioners would continue to be subject to the complaints and discipline regime under the health system for any abortion not performed in accordance with relevant standards, negligently, or without consent.
32. I propose to ensure that it be an offence for any other person to perform an abortion. Note it is already an offence under the HPCA Act for a health practitioner to practice outside their scope of practice. Health practitioners would continue to be subject to the complaints and discipline regime under the health system for any abortion not performed in accordance with relevant standards, negligently, or without consent.
33. I also propose to retain the offence of killing an unborn child, with any necessary modifications to ensure that it does not apply to lawful abortion and captures people who assault women, causing the death of a fetus.

### *Considerations*

34. Removing criminal sanctions against someone considering an abortion would diminish the stigma they face and could also reduce the risk to their mental health and well-being. Health practitioners who provide abortion services would not face the prospect of potential criminal prosecution and would also not be stigmatised.
35. It is important to continue to ensure that abortions are not performed by people who are unqualified to do so.

### **Grounds for abortion**

#### *Current framework*

36. The process to get an abortion is complex. A woman needs to be referred to abortion services by a doctor. Approval is required from two 'certifying consultants', at least one of whom must be a practising obstetrician or gynaecologist. If one of the consultants does not approve, a third certifying consultant can be consulted. Certifying consultants are specially appointed by the Abortion Supervisory Committee (the statutory oversight body under the CSA Act).
37. The certifying consultants need to decide whether the woman meets the grounds for abortion set out in the Crimes Act. These grounds are as follows:
  - For gestation of up to 20 weeks, abortion is only lawful in cases of serious danger to the life or mental health of the woman, cases of severe mental or physical "handicap" of the fetus, incest, or severe mental "subnormality" of the woman (section 187A of the Crimes Act refers).

- After the 20th week of pregnancy, abortion is lawful to save the life of the woman, or to prevent serious permanent injury to the physical or mental health of the woman.

38. If the certifying consultants agree that the legal grounds are met and the woman decides to proceed, the abortion is performed according to the provisions of the CSA Act, in premises licensed by the Abortion Supervisory Committee.

#### *Proposal*

39. I propose to repeal the current statutory grounds for abortion, and the role of and requirement for certifying consultants.

40. I propose that, for pregnancies of more than 20 weeks' gestation, the health practitioner would be required to, having regard to the pregnant woman's physical and mental health and wellbeing, reasonably believe that the abortion is appropriate.

41. For pregnancies of not more than 20 weeks' gestation, the decision whether to have an abortion would be made by the pregnant woman, in consultation with a suitably qualified health practitioner, ensuring that counselling is offered and available.

#### *Considerations*

42. I acknowledge that abortion is a difficult and sensitive issue. I believe that we need a law where a pregnant woman can and should be trusted to make the decision for themselves, in consultation with a suitably qualified health practitioner.

43. My view is that this proposal covers the right of a pregnant woman to get advice and to make a decision in consultation with a suitably qualified health practitioner.

44. Although a gestational threshold of 22 weeks was recommended by the Law Commission, I propose that the status quo of a 20 week gestational threshold is maintained.

#### **Access to abortion services**

##### *Current framework*

45. Only medical practitioners (ie doctors) can refer a pregnant woman to certifying consultants. This legislative restriction on referrals can delay access to abortion services.

##### *Proposal*

46. I propose to remove the current requirement that referrals to abortion services must be made by a doctor. A health practitioner would be able to refer a pregnant woman to appropriate services. I also propose to legislate so that a pregnant woman can self-refer to an abortion service.

### *Considerations*

47. Many women have relationships with other health practitioners such as midwives or nurses, but those practitioners cannot currently make referrals to abortion services. Health practitioners advise that getting an appointment with a General Practitioner (GP) who will refer the pregnant woman to an appropriate service can take several weeks in some areas and may require more than one appointment.
48. The Law Commission noted that where a relationship of trust and confidence exists, for example with a midwife or community nurse, these health practitioners can play an important role in supporting women to access information and to make an informed choice. This is particularly relevant for Māori for whom relationships, manaakitanga and whanaungatanga, are central. It is also important for those who do not have ready access to the internet, or who experience language or other barriers to accessing information.
49. Improving accessibility is likely to mean that the pregnant woman is seen earlier. Abortions are considerably safer when performed at earlier gestations. Earlier first trimester abortions are also generally quicker to perform and are likely to be less distressing for both the woman and the health practitioners involved.
50. In addition, enabling women to self-refer to an abortion service would further support access to services at the earliest opportunity. I understand that there are regional variations in whether District Health Boards allow self-referrals and therefore I propose including a legal provision that a pregnant woman may self-refer to an abortion service.

### ***Performing abortions***

#### *Current framework*

51. Only a doctor can currently perform an abortion. This restriction has not kept up with advances in health care or scopes of practice for health practitioners.

#### *Proposal*

52. I propose that a registered and suitably qualified health practitioner with appropriate training and experience should be able to perform an abortion, or supply products to induce an abortion, as with other health services. Whether a health practitioner can perform or assist with an abortion will be determined by their individual qualifications, registration, and scope of practice. Where a prescription medicine is supplied, the requirements under the Medicines Act 1981 would apply.
53. The Bill would ensure that no person could perform abortion services unless they are a health practitioner who is permitted to do so by their scope of practice.

### *Considerations*

54. Removing legislative restrictions would better enable scopes of practice to change as health care technology, training, and best practice advances.
55. The Health Practitioners Competence Assurance Act 2003 includes mechanisms to ensure that practitioners are competent and fit to practise. It also contains mechanisms

to ensure that certain activities are performed only by particular practitioners. I propose using HPCA Act mechanisms to ensure that surgical abortions are only performed by particular people, with modifications to these mechanisms where necessary.

56. For the purposes of medical abortions, existing mechanisms under the Medicines Act 1981 and its regulations can be used to ensure that the relevant medicines are only available on the authority of certain health practitioners. In due course, these restrictions would flow through into the new Therapeutic Products Regulatory Scheme.

### ***Conscientious objection***

#### *Current framework*

57. The Health Practitioners Competence Assurance Act 2003 imposes a duty on practitioners who object to providing abortion services or advice on the grounds of conscience to inform the pregnant woman that they can obtain the services elsewhere. This duty applies to all reproductive health services, including advice and services relating to contraception and sterilisation.
58. Similar provisions in the CSA Act state that a medical practitioner, nurse, or any other person can refuse to perform, assist in, or provide advice on abortion, sterilisation or contraception if they object to doing so on grounds of conscience.
59. Conscientious objectors are not currently required to refer the pregnant woman to another practitioner, which can delay timely access to appropriate services.

#### *Proposal*

60. I propose that a health practitioner or any other person who objects to providing services on conscience grounds must disclose their objection to the pregnant woman at the earliest opportunity and refer them to a practitioner (or other person) who can provide the service. For consistency, this change will apply where conscientious objections arise for any reproductive health services.

#### *Considerations*

61. I acknowledge the rights of health practitioners to object to providing abortion services on conscience grounds. The right to freedom of thought, conscience, religion, and belief are a fundamental part of New Zealand's human rights framework. This results in competing considerations under the New Zealand Bill of Rights Act 1990, and the right of the pregnant woman to access appropriate health care.
62. In my view, the current obligation on practitioners and other people who object does not go far enough to mitigate the risks to the pregnant woman of the potential delays, costs, and stress of having to find another health practitioner. The right of the practitioner to object to providing the services, and the right of the woman to access the services in a timely way, must be appropriately balanced.

#### *Additional issue relating to conscientious objection*

63. I have become aware that the provision in the CSA Act also makes it unlawful for an employer to refuse to hire someone because they are a conscientious objector in



respect of abortion (or sterilisation or contraception). An employer also cannot make a recruitment offer conditional on the person agreeing not to conscientiously object to performing the relevant procedures. In practice this means District Health Boards when recruiting cannot ask candidates about whether they will object, and cannot give preference to candidates who are willing to provide abortion services. This could foreseeably have an impact on the availability of abortion services in smaller centres or locations.

64. This provision does not align with the Human Rights Act 1993, which provides protection in employment matters to people with religious or ethical beliefs, while also recognising that rights are not absolute, allowing employers to balance other factors.
65. I propose to consult coalition and confidence and supply parties on this issue in the coming weeks. I seek power to act so, following this consultation, I can direct officials as to whether and how this issue might be progressed in the draft Bill. I would inform Cabinet of the outcome and what has been reflected in the Bill when the Bill is considered by the Cabinet Legislation Committee.

### ***Licensing of premises***

#### *Current framework*

66. All abortions must take place at a facility licensed by the Abortion Supervisory Committee. The Committee will only grant a licence if it is satisfied that certain requirements are met, including adequacy of surgical facilities.
67. The law also requires women to take both doses of medication for early medical abortion (EMA) at a licensed facility.

#### *Proposal*

68. General health law has several mechanisms that regulate the safety of health facilities and the availability of medication. I propose that the safety of facilities providing surgical abortion services be regulated in the same way as other health facilities. The provision of surgical abortion services by private health providers and in day surgeries would continue to operate as other surgical services do currently.
69. For the provision of EMA, I propose Cabinet agree to further work to ensure that the relevant medicines for medical abortions are only available on the authority of appropriate health practitioners, through regulations created under the Medicines Act 1981. Regulations can impose conditions and limitations associated with the provision of the relevant medicines.

#### *Considerations*

70. I understand that licensing requirements can be a barrier to access to services in some areas. Some facilities may only have a limited licence, and the licensing process and criteria may prevent or discourage new clinics from opening. As a result, the pregnant woman may not have a choice about the type of abortion they have, or they may have to travel to another area to access an appropriate service.

71. Currently, EMA must be performed in a licensed facility. I am advised that EMA is not a surgical procedure and could be safely administered in other health settings, or at home. EMA is less invasive than surgical abortion. I understand that the requirement for EMA to be performed in a licensed facility has the potential to delay the procedure to the stage where EMA is no longer an option, depending on access to licensed facilities and services in the area.
72. The Abortion Supervisory Committee told the Law Commission that allowing women to take the second dose of medication at home would be safer than the current arrangement, because women may begin to miscarry while travelling home from the licensed institution. However this raises concerns around the care for the woman's health during the EMA induced miscarriage should she be home alone and find herself in physical or mental distress.
73. Health practitioners also suggested that enabling the provision of EMA by smaller health facilities could help improve access – especially in smaller and more isolated centres such as the West Coast, where a dedicated abortion clinic may not be sustainable.
74. However the treatment is not suitable if the pregnant woman does not have a telephone or lives more than one hour from emergency hospital medical services. This is in case the patient experiences heavy bleeding that may require treatment and again raises concerns for the woman's physical and mental health.
75. Under general health law, hospitals must be certified under the Health and Disability Services (Safety) Act 2001. Smaller service providers, such as medical centres, pharmacists, and sexual health clinics, are subject to a range of other standards and requirements. This includes the prescription and supply of medicine.
76. Decisions about the location of public services are made by District Health Boards based on a range of considerations. The removal of the licensing system would mean that these decisions are made in the same way that service planning is done for other health services. I am advised that it is likely that this would reduce some of the barriers to access in some areas.

*For future consideration*

77. s9(2)(g)(i), s9(2)(g)(ii)  
[Redacted text]

***Informed consent and capacity***

*Current framework*

78. General health law and other legislation governs the approach to ensuring that a pregnant woman, including those under the age of 16, has given informed consent to abortion.

79. Health practitioners have a duty to ensure a woman seeking health services has access to appropriate information, in a way that is accessible and clear to the woman seeking the information, irrespective of any disability, sensory limitations, learning needs, or language barriers, and sufficient time to reflect on the information. Failure to do so is a breach of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.
80. Under the Care of Children Act 2004, consent to abortion by a female child of any age, or refusal to consent, is treated as though the child was of full age. The law does not require the involvement of the child's parents unless she lacks capacity to consent for reasons other than her age. Parents may seek access to the child's health information; however, the person or agency that holds the information may refuse to disclose it.
81. Under general health law, every person is presumed to be competent to give informed consent unless the health practitioner has reasonable grounds for believing otherwise. If the health practitioner is unable to ascertain the person's views, the Medical Council recommends that they consult an experienced colleague before proceeding. There is a provision in the CSA Act which effectively duplicates these existing health processes for abortion.
82. There are also other established legal protections for people with diminished mental capacity, in addition to those in the health framework.

#### *Proposal*

83. I am not proposing any changes to the current laws around informed consent or parental notification.
84. I propose to repeal the duplicative provision in the CSA Act that refers to capacity to consent. I am not proposing any other changes to the laws relating to diminished capacity at this time.

#### **Counselling**

##### *Current framework*

85. The CSA Act requires women to be informed of their right to seek counselling after an abortion has been either approved or refused. I understand that, in practice, counselling is usually offered earlier (either by the GP or Family Planning doctor, or when the woman first attends an abortion service). It is not mandatory for the pregnant woman to participate in counselling.

##### *Proposal*

86. I propose that counselling must continue to be made available, but not mandatory, for pregnant women considering an abortion or those who have had an abortion.

##### *Considerations*

87. I understand that the availability of counselling could be ensured through the discharge by a GP of their professional obligation to have regard to the overall wellbeing of their

patient. However, I think it is important to ensure that appropriate counselling services are available to those who wish to access it, by providing for this in legislation.

88. The Abortion Supervisory Committee's Standards of Care state that women should be offered pre-decision/pregnancy options counselling, pre-abortion counselling, as well as post-abortion counselling.
89. As well as the current obligations to offer counselling to patients, health practitioners have a statutory obligation to comply with the Code of Health and Disability Services Consumers' Rights (the Code). Under the Code every patient has the right to make an informed choice and to give informed consent.

### **Oversight of abortion services**

#### *Current framework*

90. Under the CSA Act, the Abortion Supervisory Committee has oversight of abortion services. This includes approving certifying consultants, licensing facilities, and issuing standards of care and best practice guidelines. The CSA Act is administered by the Ministry of Justice.
91. The guidelines and standards issued by the Abortion Supervisory Committee have no legal status. The Committee has no ability to enforce the standards other than by declining or limiting licences (which must be reviewed annually).

#### *Proposal*

92. I propose that the oversight of abortion services be transferred to the Ministry of Health.
93. The provisions of the CSA Act relating to the constitution, powers, and functions of the Abortion Supervisory Committee would be repealed, and the Committee would be disestablished.
94. The Ministry of Health would be responsible for ensuring the development of best practice guidelines/standards of care for abortion services, and data collection and monitoring, in consultation with abortion service providers and Māori. Regulations will be required to support the exercise of the data collection and monitoring functions.
95. To fulfil its responsibilities to provide robust oversight of abortion services, the Ministry of Health may establish a committee similar in design and operation to other health monitoring groups such as the National Maternity Monitoring Group. The committee could advise the Director-General of Health, providing oversight and review of abortion services' standards, analysis and reporting, and provide advice to the Ministry and District Health Boards on priorities for improvements. Clinical indicators could be developed by the committee and used as a basis for their reviews and reporting.

#### *Considerations*

96. To achieve the intent of these proposals, the oversight of abortion services should be aligned with the oversight of other health services but also recognise the seriousness with which we as a nation consider of the quality and provision of this service for

women. The Ministry of Health would be responsible for ensuring appropriate distribution and funding of abortion services, either directly or through District Health Boards, which is consistent with other health services.

97. Under the current health system, the Ministry of Health can only require public providers to collect data. The current abortion system is well-established to collect extensive information relating to abortions. Regulations would be needed to ensure that both public and private providers provide robust and accurate data relating to abortion provision, to meet the high level of public interest in abortion statistics

### **Safe access zones**

#### *Current status of safe access zones*

98. Safe access zones aim to protect women accessing abortion services from intimidation by protesters. Safe access zones are areas within a specified radius of an abortion facility. Safe access zone legislation makes certain behaviour within the zone an offence, such as harassing any person entering or leaving the premises where abortions are performed.
99. Safe access zones have not been introduced in New Zealand. They have been initiated in some overseas jurisdictions including several states and provinces in Australia, Canada, and the United States.

#### *Proposal*

100. I propose the inclusion of a regulation-making power, so that a safe access zone could be implemented to prevent harm to pregnant women or health practitioners accessing a specific facility.

#### *Considerations*

101. Safe access zones may support equity of access to abortion services and may serve to reduce stigma experienced by women and medical practitioners, therefore supporting the provision of safe clinical care. A provision for safe access zones would proactively safeguard women accessing abortion clinics against future harm.
102. The introduction of safe access zones would engage rights such as peaceful assembly, freedom of association, and freedom of expression. There are competing considerations under the New Zealand Bill of Rights Act 1990, and the right to access health services safely.
103. As with conscientious objection, to justify limits on freedoms, a sufficiently important objective must be identified and the limit on rights must be rationally connected and proportionate to the objective.
104. I consider that the protection of a person's right to access health services safely and free from harassment is a sufficiently important objective. Care will need to be taken to ensure that the restrictions on these rights in any regulations go no further than necessary to achieve the objective in a proportionate manner.

## Next steps

105. If Cabinet agrees, I will issue drafting instructions to the Parliamentary Counsel Office to prepare a bill reflecting the proposals set out in this paper.
106. I seek agreement that, given the conscience nature of these proposals, members of Cabinet will be permitted to oppose the Bill, or promote or support a Supplementary Order Paper to change the Bill during the Committee of the whole House.

## Consultation

107. The Law Commission consulted with health professionals and sought the public's views during the development of its briefing paper. The Commission received a total of 3,419 submissions from a diverse range of individuals and organisations.
108. With the assistance of the Ministry of Health, the Law Commission held a meeting with representatives of health professional bodies and abortion service providers (including District Health Boards) while developing its advice. This allowed the Commission to test the likely workability of the options for reform it had identified.
109. The Law Commission received submissions online, by email, and by post. The period for public submissions ran from 4 April to 18 May 2018.
110. Of the total submissions received, 61 were from organisations such as government bodies, professional organisations, academic groups, religious organisations and interest groups. Four submissions were made by peer groups within professions, and the remaining 3,354 submissions were from people speaking in their personal capacity. A significant number of personal submissions were based on the Family First New Zealand pamphlet "I'm with both", which was produced to assist people to make a submission. These submissions followed similar themes and included similar or identical comments.
111. The Law Commission noted that some submitters made duplicate or follow up submissions, which were recorded as separate submissions. In addition, most submitters addressed only a small number of issues which were of particular concern to them or did not express a view on law reform.<sup>1</sup>
112. The following departments have been consulted on the proposals in this paper: the Ministry of Health, the Ministry for Women, the Office for Disability Issues, the Treasury, the Ministry for Pacific Peoples, NZ Police, and Te Puni Kōkiri.
113. New Zealand First and the Green Party of Aotearoa New Zealand have been consulted on the proposals in this paper.
114. New Zealand First noted their historical policy position of "safe, rare and legal" when addressing this topic. It is their view that "safe and legal" have been addressed in this paper even though they still retain concerns around the prompt and consistent provision of mental health services to those women who find themselves requiring this service. With regard to "rare" it is their view that with the shifting of this service to the health sector we are provided with a greater ability to collect anonymised data on the

---

<sup>1</sup> Law Commission briefing paper, pages 208-209

circumstances that have led individual women to seek this service. That information will allow the government to better plan for resourcing that might directly impact on the reduction of need for this specific service over time.

115. The Department of the Prime Minister and Cabinet has been informed.

### **Financial Implications**

116. I anticipate that overall funding implications of the proposals would be minimal. The funding held by Vote Courts for payments to certifying consultants held in the non-departmental other expense appropriation *Abortion Supervisory Committee – Certifying Consultants Fee* is approximately \$5.0 million per annum. This ongoing funding will need to be transferred in total to Vote Health as the Ministry of Health would assume full responsibility for oversight and monitoring of abortion services. The transfer will be fiscally neutral. The funding will be transferred into existing appropriations within Vote Health and any expenses occurred by the Ministry of Health prior to the transfer will be managed within baselines. The normal budget cycle would incorporate any future funding decisions for abortion services within Vote Health.

### **Legislative Implications**

117. An omnibus bill will be required to make amendments to the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977, and to make new provisions relating to abortion.

118. Amendments to the Health Practitioners Competence Assurance Act 2003, and other consequential amendments to health legislation, may also be required.

119. s9(2)(g)(i), s9(2)(g)(ii)

120. The Bill will bind the Crown.

### **Impact Analysis**

121. An Impact Analysis has been prepared and is attached to this paper.

122. A Quality Assurance Panel with representatives from the Ministry of Justice and the Treasury Regulatory Quality Team has reviewed the 'Abortion Law Reform' Regulatory Impact Assessment (RIA) produced by the Ministry of Justice and dated May 2019.

123. Overall, the Panel considers that the RIA meets the Quality Assurance criteria, with a couple of notes.

### *Gestational limits*

124. The RIA has two options under Model C for 'gestational limits': no statutory test up to 20 weeks, and no statutory test up to 22 weeks. The RIA contains information about some of the types of impacts of having a gestational limit versus no limit, but would be improved with information about the relative impacts of different gestational limits, for instance additional constraints or costs (e.g. stress; having to seek an abortion from a

health professional that is not the person's preferred choice) because of an approaching limit.

#### *Structure of the RIA*

125. The RIA is somewhat unique in that some significant matters are treated in a value-neutral way. These matters are the grounds for abortion and conscientious objection by health practitioners. For these matters, impacts are analysed but the options are not assessed for how well they achieve particular objectives. This is to support Members of Parliament and the public to make their own judgements on matters that Parliament is likely to treat as conscience issues.
126. Other matters relate to regulation of access to, and oversight of, abortion services. For these matters, options have been assessed against criteria and objectives that support a 'health approach'.
127. The Panel considers that this structure is sound.

#### **Human Rights**

128. Moving to a health approach is more consistent with our international human rights obligations. International human rights bodies consider abortion as a matter of sexual and reproductive health and that it should not be criminalised.
129. The proposals relating to the grounds for abortion, conscientious objection and safe access zones raise considerations under the Bill of Rights Act 1990. They engage rights such as freedom of expression, freedom of thought, conscience, religion and belief, peaceful assembly, freedom of association and freedom from discrimination.
130. To justify limits on freedoms, a sufficiently important objective must be identified and the limit on rights must be rationally connected and proportionate to the objective. In my view, the objectives of these proposals are sufficiently important to meet this requirement and that the proposed restrictions on these rights go no further than necessary to achieve the objective in a proportionate manner.

#### **Gender Implications**

131. The current starting point for abortion is that it is a crime. No other health service begins with such a heavy stigma of criminality. This means that a woman's health and wellbeing is not the primary consideration when she is seeking abortion services. The right to bodily autonomy is compromised, because decisions about her body and reproductive choices are governed by our criminal laws and the complex procedural requirements.
132. By its nature, abortion laws have significant implications for women. Taking a health approach to abortion puts a clear emphasis on the health, rights and wellbeing of women. It would enable women to make their own decisions about what happens with their bodies.



## Disability Perspective

133. Several submitters to the Law Commission’s briefing paper expressed concern that decriminalisation would lead to an increase in abortions due to fetal disability or potential abnormality. Others commented on the difficulty of the decisions women face when learning the condition of the fetus is not as they hoped or expected. They said, in these circumstances, the decision to abort is a matter for the woman alone to determine in her circumstances. These matters are complex and are generally closely related to the availability of prenatal screening, developments in screening techniques and the attitudes of the New Zealand public about disability and towards disabled people. It is also important to acknowledge disabled people’s experiences of discriminatory behaviours. This speaks to wider changes that are needed within New Zealand society to improve lived experiences for disabled people and to shift toward a more nuanced and positive understanding of disability among the New Zealand public. This was a common theme identified by disabled people during recent consultation on a draft Disability Action Plan 2019-2022.
134. New Zealand’s Independent Monitoring Mechanism on the Convention on the Rights of Persons with Disabilities has expressed concern about antenatal screening and abortions in New Zealand. It observed, in the context of antenatal screening, that an approach that has the effect of preventing the births of a protected minority group could be discriminatory. It increases stigma in society, means there are fewer people with lived experience to advocate for protections and services, and adds to the notion that disability is a negative experience rather than a facet of human diversity.<sup>2</sup>
135. These matters are complex and are generally closely related to the availability of prenatal screening, and developments in screening techniques.
136. It is important to ensure that pregnant women whose fetuses show signs of disability are provided with and/or have access to fair, full and balanced information in a format accessible to them. This should include information about the potential disability and the existing supports available so that they can make an informed choice around whether or not to continue the pregnancy.
137. The current grounds for abortion under the Crimes Act (section 187A refers) include:
- that there is a substantial risk that the child, if born, would be “so physically or mentally abnormal as to be seriously handicapped”; and
  - where the (pregnant) woman or girl is “severely subnormal”.
138. These references to the fetus and the pregnant woman in the current grounds for abortion may contribute to a negative perception of people with disabilities. The proposals in this paper appropriately remove these as specific considerations.

## Publicity

139. The proposals contained in this paper will attract significant public and media interest. s9(2)(g)(i), s9(2)(g)(ii)

---

<sup>2</sup> Law Commission briefing paper, page 60

## Proactive Release

140. This paper will be proactively released when a bill is introduced to the House of Representatives.

## Recommendations

141. The Minister of Justice recommends that the Committee:

1. **note** that the current law around abortion is now over forty years old and its starting point is that abortion is a crime
2. **note** that on 26 October 2018, the Law Commission provided me with its briefing paper *Alternative approaches to abortion law*, which describes changes that could be made to remove the criminal aspects from abortion law and align it with a health approach
3. **note** that the current framework for abortion law is set out in the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977
4. **agree** that the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977 be amended as follows:
  - 4.1. the offence relating to pregnant women who procure abortions be repealed
  - 4.2. the current offences which specifically criminalise health practitioners' activities relating to abortion be repealed
  - 4.3. an offence be retained for people who perform abortions (if they are not a registered and suitably qualified health practitioner with appropriate training and experience)
  - 4.4. the offence of killing an unborn child be retained with any necessary amendments to ensure that it does not apply to lawful abortion, and captures people who assault women causing the death of a fetus
5. **agree** that the statutory grounds for abortion in the Crimes Act 1961 be repealed
6. **agree** that the current procedure for seeking an abortion under the Contraception, Sterilisation, and Abortion Act 1977 be repealed
7. **agree** that for pregnancies of more than 20 weeks' gestation the health practitioner would be required to, having regard to the pregnant woman's physical and mental health and wellbeing, reasonably believe that the abortion is appropriate
8. **note** that for pregnancies of not more than 20 weeks' gestation, the decision to have an abortion would be made by the pregnant woman, in consultation with a suitably qualified health practitioner
9. **note** that abortion services would only be able to be performed by a registered and suitably qualified health practitioner with appropriate training and experience

10. **agree** that further work be undertaken to ensure that the relevant medicines for medical abortions are only available on the authority of appropriate health practitioners and with conditions as required, and note this can be achieved through regulations created under the Medicines Act 1981
11. **agree** that amendments to the Health Practitioners Competence Assurance Act 2003, and other consequential amendments to health legislation (including the Health and Disability Commissioner Act 1994, the New Zealand Public Health and Disability Act 2000 and the Medicines Act 1981), are made as required to give effect to the proposals in this paper
12. **agree** that a health practitioner or any other person who objects to providing reproductive health services, including abortion and contraception, on the grounds of conscience must disclose their objection to the person at the earliest opportunity and refer them to another practitioner (or other person) who will provide the service
13. **authorise** the Minister of Justice to have power to act to issue drafting instructions on the issue of employment protections for those who have a conscientious objection, after consultation with coalition and confidence and supply parties, and with other Ministers as appropriate, and Cabinet will be informed of the outcome and what has been reflected in the Bill when the Bill is considered by the Cabinet Legislation Committee
14. **agree** that statutory provision be made for a pregnant woman to self-refer to an abortion service
15. **agree** that the Contraception, Sterilisation, and Abortion Act 1977 be amended as follows:
- 15.1. the Abortion Supervisory Committee be disestablished, including repealing all of its duties, powers and functions
  - 15.2. the provisions relating to certifying consultants be repealed
  - 15.3. counselling services be available to women considering an abortion or who have had an abortion in a timely manner
  - 15.4. the provision relating to capacity to consent be repealed
  - 15.5. the provisions relating to the licensing of facilities be repealed
16. **agree** that regulation-making powers be included to:
- 16.1. enable the Ministry of Health to require public and private abortion providers to provide robust and accurate data
  - 16.2. provide for safe access zones where necessary because of harm to pregnant women or health practitioners accessing a specific facility
17. **note** that as a consequence of these policy proposals, the operational processes under the general health system will apply to:

- 17.1. access to services (except for self-referral)
- 17.2. the qualifications of health practitioners performing or administering an abortion
- 17.3. the safety of premises and availability of medication
- 17.4. oversight of abortion services
18. **note** that no changes are proposed to the laws around informed consent or parental notification for abortion
19. **note** that no change is proposed to the laws relating to diminished capacity at this time
20. **note** that it is intended to transfer the existing funding of approximately \$5.0 million per annum held in Vote Courts for payments to certifying consultants held in non-departmental other expense appropriation *Abortion Supervisory Committee – Certifying Consultants Fee* to Vote Health when the legislation is passed to enable Ministry of Health to fulfil its responsibilities for oversight and monitoring of abortion services.
21. **note** the Ministers for Courts, of Finance and Health will approve the fiscally neutral appropriation transfers between Vote Courts and Vote Health required to effect the proposals in this paper
22. **invite** the Minister of Justice to issue drafting instructions to give effect to the above proposals
23. **agree** that the Minister of Justice be authorised to make additional minor policy decisions within the overall framework approved by Cabinet, but any major policy issues will be subject to further Cabinet consideration
24. **agree** that, given the conscience nature of these proposals, members of Cabinet will be permitted to oppose the Bill, or promote or support a Supplementary Order Paper to change the Bill during the Committee of the whole House.
25. **s9(2)(g)(i), s9(2)(g)(ii)** .

Authorised for lodgement

Hon Andrew Little  
Minister of Justice



# Cabinet Social Wellbeing Committee

## Minute of Decision

---

*This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.*

---

### Taking a Health Approach to the Regulation of Abortion

Portfolio                      Justice

On 22 May 2019, the Cabinet Social Wellbeing Committee:

- 1        **noted** that the current law around abortion is now over forty years old and its starting point is that abortion is a crime;
- 2        **noted** that on 26 October 2018, the Law Commission provided the Minister of Justice with its briefing paper *Alternative approaches to abortion law*, which describes changes that could be made to remove the criminal aspects from abortion law and align it with a health approach;
- 3        **noted** that the current framework for abortion law is set out in the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977;
- 4        **agreed** that the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977 be amended as follows:
  - 4.1      the offence relating to pregnant women who procure abortions be repealed;
  - 4.2      the current offences which specifically criminalise health practitioners' activities relating to abortion be repealed;
  - 4.3      an offence be retained for people who perform abortions (if they are not a registered and suitably qualified health practitioner with appropriate training and experience);
  - 4.4      the offence of killing an unborn child be retained with any necessary amendments to ensure that it does not apply to lawful abortion, and captures people who assault women causing the death of a fetus;
- 5        **agreed** that the statutory grounds for abortion in the Crimes Act 1961 be repealed;
- 6        **agreed** that the current procedure for seeking an abortion under the Contraception, Sterilisation, and Abortion Act 1977 be repealed;
- 7        **agreed** that for pregnancies of more than 20 weeks' gestation the health practitioner would be required to, having regard to the pregnant woman's physical and mental health and wellbeing, reasonably believe that the abortion is appropriate;

- 8 **noted** that for pregnancies of not more than 20 weeks' gestation, the decision to have an abortion would be made by the pregnant woman, in consultation with a suitably qualified health practitioner;
- 9 **noted** that abortion services would only be able to be performed by a registered and suitably qualified health practitioner with appropriate training and experience;
- 10 **agreed** that further work be undertaken to ensure that the relevant medicines for medical abortions are only available on the authority of appropriate health practitioners and with conditions as required, and note this can be achieved through regulations created under the Medicines Act 1981;
- 11 **agreed** that amendments to the Health Practitioners Competence Assurance Act 2003, and other consequential amendments to health legislation (including the Health and Disability Commissioner Act 1994, the New Zealand Public Health and Disability Act 2000 and the Medicines Act 1981), are made as required to give effect to the decisions in the paper under SWC-19-SUB-0055;
- 12 **agreed** that a health practitioner or any other person who objects to providing reproductive health services, including abortion and contraception, on the grounds of conscience must disclose their objection to the person at the earliest opportunity and refer them to another practitioner (or other person) who will provide the service;
- 13 **invited** the Minister of Justice to act to issue drafting instructions on the issue of employment protections for those who have a conscientious objection, after consultation with coalition and confidence and supply parties, and with other Ministers as appropriate, and Cabinet will be informed of the outcome and what has been reflected in the Bill when the Bill is considered by the Cabinet Legislation Committee;
- 14 **agreed** that statutory provision be made for a pregnant woman to self-refer to an abortion service;
- 15 **agreed** that the Contraception, Sterilisation, and Abortion Act 1977 be amended as follows:
- 15.1 the Abortion Supervisory Committee be disestablished, including repealing all of its duties, powers and functions;
  - 15.2 the provisions relating to certifying consultants be repealed;
  - 15.3 counselling services be available to women considering an abortion or who have had an abortion in a timely manner;
  - 15.4 the provision relating to capacity to consent be repealed;
  - 15.5 the provisions relating to the licensing of facilities be repealed;
- 16 **agreed** that regulation-making powers be included to:
- 16.1 enable the Ministry of Health to require public and private abortion providers to provide robust and accurate data;
  - 16.2 provide for safe access zones where necessary because of harm to pregnant women or health practitioners accessing a specific facility;

- 17 **noted** that as a consequence of these policy proposals, the operational processes under the general health system will apply to:
- 17.1 access to services (except for self-referral);
  - 17.2 the qualifications of health practitioners performing or administering an abortion;
  - 17.3 the safety of premises and availability of medication;
  - 17.4 oversight of abortion services;
- 18 **noted** that no changes are proposed to the laws around informed consent or parental notification for abortion;
- 19 **noted** that no change is proposed to the laws relating to diminished capacity at this time;
- 20 **noted** that it is intended to transfer the existing funding of approximately \$5.0 million per annum held in Vote Courts for payments to certifying consultants held in non-departmental other expense appropriation *Abortion Supervisory Committee – Certifying Consultants Fee* to Vote Health when the legislation is passed, to enable the Ministry of Health to fulfil its responsibilities for oversight and monitoring of abortion services;
- 21 **noted** that the Ministers for Courts, of Finance and Health will approve the fiscally neutral appropriation transfers between Vote Courts and Vote Health required to effect the decisions set out above;
- 22 **invited** the Minister of Justice to issue drafting instructions to give effect to the above decisions;
- 23 **authorised** the Minister of Justice to make additional minor policy decisions within the overall framework approved by Cabinet, but any major policy issues will be subject to further Cabinet consideration;
- 24 **agreed** that, given the conscience nature of these proposals, members of Cabinet will be permitted to oppose the Bill, or promote or support a Supplementary Order Paper to change the Bill during the Committee of the whole House;
- 25 **invited** the Leader of the House to consider options for an ad hoc select committee to consider the Bill;
- 26 s9(2)(g)(ii)

Gerrard Carter  
Committee Secretary

---

**Hard-copy distribution: (see over)**

**Present:**

Rt Hon Jacinda Ardern  
Rt Hon Winston Peters  
Hon Kelvin Davis  
Hon Grant Robertson  
Hon Phil Twyford  
Hon Chris Hipkins  
Hon Andrew Little  
Hon Carmel Sepuloni (Chair)  
Hon Nanaia Mahuta  
Hon Stuart Nash  
Hon Jenny Salesa  
Hon Tracey Martin  
Hon Peeni Henare  
Hon Willie Jackson  
Hon Aupito William Sio  
Hon Julie Anne Genter  
Michael Wood, MP  
Jan Logie, MP

**Officials present from:**

Office of the Prime Minister  
Office of the Chair  
Officials Committee for SWC

**Hard-copy distribution:**

Minister of Justice

RELEASED BY THE MINISTER OF JUSTICE



Chair

Cabinet Legislation Committee

## **Abortion Legislation Bill 2019: Approval for Introduction**

### **Proposal**

- 1 This paper seeks approval for the introduction of the Abortion Legislation Bill 2019 (the Bill). It also signals areas where I have made additional policy decisions in accordance with the authority granted by Cabinet.

### **Policy**

- 2 On 27 May 2019, Cabinet agreed to amend the laws relating to abortion to decriminalise abortion and align the regulation of abortion services in New Zealand with other health services [CAB SWC-19-MIN-0055 and CAB-19-MIN-0238 refer].

### *Background*

- 3 The law relating to abortion is over forty years old. The framework for abortion law is set out in the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977.
- 4 Performing an unlawful abortion is a criminal offence in New Zealand. An abortion is unlawful unless certain legal grounds are met. Two specially appointed doctors, called certifying consultants, must be satisfied that one of the grounds applies before an abortion can occur. It is also an offence, punishable by a fine, for a woman to unlawfully procure her own miscarriage or obtain an unlawful abortion.
- 5 In February 2018, I asked the Law Commission for advice on what treating abortion as a health matter could look like. The Law Commission reported back on 26 October 2018 with its briefing paper *Alternative approaches to abortion law*, which describes changes that could be made to remove the criminal aspects from abortion law and align it with a health approach. The amendments contained in the Bill are informed by the options and discussion in the Law Commission briefing paper.

### *Key aspects of the Bill*

- 6 The Bill amends the law to:
  - decriminalise abortion
  - better align the regulation of abortion services with other health services
  - modernise the legal framework for abortion.

7 The Bill's main changes include provisions to:

- repeal the offences relating to women who procure abortions, and that specifically criminalise health practitioners' activities relating to abortion
- repeal the statutory procedure and grounds for abortions, including the need for certifying consultants
- provide that for pregnancies of up to 20 weeks' gestation, the decision to have an abortion would be made by the woman, in consultation with a qualified health practitioner
- provide that for pregnancies of more than 20 weeks' gestation the health practitioner may not perform an abortion unless they reasonably believe, having regard to the woman's physical and mental health and wellbeing, that the abortion is appropriate
- provide that a person who objects to providing services on the grounds of conscience must disclose their objection to the person seeking services at the earliest opportunity and tell them how they can access information about providers of the service, which must be made available by the Director-General of Health
- ensure that a woman may access abortion services without a referral from a health practitioner
- ensure the availability of counselling services, and that health practitioners advise women of the availability of counselling services
- create an offence for people who are not health practitioners who perform an abortion
- provide for the establishment of a safe area where required for specific premises, to protect safety and wellbeing, and respect the privacy and dignity of people accessing or providing services at the premises
- disestablish the Abortion Supervisory Committee, including repealing all its duties, powers and functions.

8 The changes will mean that abortion is, in general, provided like other health services. The safety of health services in New Zealand is regulated by a range of legislation that provides for:

- the right of health consumers to receive an appropriate standard of care, the right to access information and be fully informed, and the right to give informed consent, under the Health and Disability Commissioner Act 1994 and Code of Health and Disability Services Consumers' Rights
- mechanisms to ensure that health practitioners are suitably qualified, competent and fit to practise their professions, under the Health Practitioners Competence Assurance Act 2003

- limitations on who can supply or administer prescription medicine, in accordance with a prescription given by an authorised health practitioner, under the Medicines Act 1981
- avenues for health consumers to make complaints about their care and for complaints to be independently assessed by the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994 and Code of Health and Disability Services Consumers' Rights.

### **Additional policy decisions**

#### *Conscientious objection in the employment context*

- 9 Cabinet invited me to act to issue drafting instructions on the issue of employment protections for those who have a conscientious objection, after consultation with coalition and confidence and supply parties, and with other Ministers as appropriate [CAB SWC-19-MIN-0055]. The current provisions mean that District Health Boards and service providers wanting to recruit individuals to provide care that may include abortion services cannot ask candidates about whether they will object. This means that employers cannot balance the right for individuals to conscientiously object to abortion with the employer's need to provide health services.
- 10 I have instructed that the Bill include provisions, based on the principles of the Human Rights Act 1993, to make it unlawful to discriminate based on conscientious objection and requiring an employer to accommodate a qualified person who had a conscientious objection. However, the accommodation of the objection must only be to the extent that the objection would not unreasonably disrupt the employer's ability to provide the abortion service. This change is intended to balance the right to conscientious objection with the role of employers in providing health services.
- 11 The Bill also provides for applicants or employees to have the option of using existing processes under the Human Rights Act or the Employment Relations Act 2000 for dealing with employment disputes that allege discrimination.

#### *Availability of counselling services*

- 12 I was also authorised by Cabinet to make additional minor policy decisions within the overall framework approved by Cabinet, with any major policy issues subject to further Cabinet consideration [CAB-19-MIN-0238].
- 13 During the drafting process I made an additional minor policy decision that is reflected in the Bill. This provides additional clarity that counselling services must be available to women considering an abortion, or who have had an abortion.
- 14 The Bill now requires the Minister of Health to take reasonable and practicable steps to ensure counselling services are available throughout New Zealand, utilising mechanisms under the New Zealand Public Health and Disability Act 2000.

*Contraception, Sterilisation, and Abortion Act 1977 should be binding on the Crown*

- 15 Cabinet Circular (02) 4: *Acts Binding the Crown: Procedures for Cabinet Decision* notes that bills that are amending existing Acts will generally follow the position of the principal Act on whether the Act is binding on the Crown. The Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) does not provide that the Act binds the Crown.
- 16 Considering the Bill makes substantive changes to the CSA Act, it is appropriate to review the binding nature of the principal Act. The general principle is that the Crown should be bound by Acts unless the application of a particular Act to the Crown would impair the efficient functioning of the Government.
- 17 As there are powers and obligations for the Crown provided under the Bill, the CSA Act should bind the Crown as its purpose would be otherwise defeated.

**Impact analysis**

- 18 An impact analysis was prepared in accordance with Cabinet requirements and was submitted to Cabinet along with the paper seeking policy approvals in May 2019 [CAB SWC-19-MIN-0055 and CAB-19-MIN-0238 refer].

**Compliance**

- 19 The Bill complies with the following:
- 19.1 the principles of the Treaty of Waitangi;
  - 19.2 the rights and freedoms contained in the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993;
  - 19.3 the disclosure statement requirements (a disclosure statement prepared by the Ministry of Justice is attached);
  - 19.4 the principles and guidelines set out in the Privacy Act 1993;
  - 19.5 relevant international standards and obligations; and
  - 19.6 the *Legislation Guidelines* (2018 edition), which are maintained by the Legislation Design and Advisory Committee.

*Discussion on safe areas*

- 20 I note that new section 17 in the Bill enables regulations to be made to prescribe a safe area for specific premises, where necessary. The purpose of this regulation making power is to protect the safety and wellbeing, and respect the privacy and dignity, of women accessing abortion facilities or practitioners providing or assisting with abortion services. The establishment of a safe area would engage rights under the New Zealand Bill of Rights Act 1990 (BORA) such as freedom of expression.
- 21 Once a safe area is prescribed, a person who engages in prohibited behaviour within the area commits an offence. The Bill defines what behaviour is prohibited, which

includes communicating in a manner intended to cause emotional distress. The Bill states that the boundary of a safe area can be no more than 150 metres from the premises.

- 22 The Act is not intended to empower secondary legislation that is inconsistent with BORA. While any future regulations could prima facie limit BORA rights, the regulations are only intended to be used where there is sufficient justification to limit rights. Any regulations made where there is insufficient justification could be considered by a court to be *ultra vires* or drawn to the attention of the House by the Regulations Review Committee.
- 23 I consider that including safe areas in secondary legislation is the least restrictive way to limit rights impacted by a safe area being established. If safe areas were included in primary legislation they would have much broader application (for example, applying to all places where abortion is performed).

#### *Discussion on conscientious objection*

- 24 I note that the conscientious objection provisions engage BORA rights such as freedom of thought, conscience, religion and belief. I consider that the Bill balances the right to conscientious objection with the right of individuals to access health care in a timely manner, and with the role of employers in providing health services.

#### **Consultation**

- 25 The Law Commission consulted with health professionals and sought the public's views during the development of its briefing paper. The Commission received a total of 3,419 submissions from a diverse range of individuals and organisations.
- 26 With the assistance of the Ministry of Health, the Law Commission held a meeting with representatives of health professional bodies and abortion service providers while developing its advice. This allowed the Commission to test the likely workability of the options for reform it had identified.
- 27 The Law Commission received submissions online, by email, and by post. The period for public submissions ran from 4 April to 18 May 2018.
- 28 Of the total submissions received, 61 were from organisations such as government bodies, professional organisations, academic groups, religious organisations and interest groups. Four submissions were made by peer groups within professions, and the remaining 3,354 submissions were from people speaking in their personal capacity. A significant number of personal submissions were based on the Family First New Zealand pamphlet "I'm with both", which was produced to assist people to make a submission. These submissions followed similar themes and included similar or identical comments.
- 29 The Law Commission noted that some submitters made duplicate or follow up submissions, which were recorded as separate submissions. In addition, most

submitters addressed only a small number of issues which were of particular concern to them or did not express a view on law reform.<sup>1</sup>

30 The following departments have been consulted on the proposals in this paper: the Ministry of Health, the Ministry for Women, the Office for Disability Issues (within MSD), the Treasury, the Ministry for Pacific Peoples, NZ Police, and Te Puni Kōkiri.

31 The Department of the Prime Minister and Cabinet has been informed.

### **Creating new agencies or amending law relating to existing agencies**

32 The Bill does not create any new agencies or amend the law relating to existing agencies. However, the Bill disestablishes the Abortion Supervisory Committee and repeals its duties, powers and functions.

### **Allocation of decision making powers**

33 The Bill does not involve the allocation of decision-making powers between the executive, the courts or tribunals.

### **Associated regulations**

34 No regulations are needed to bring the Bill into operation. The Bill contains provisions that allow regulations to be made, if required, to:

34.1 support the exercise of the data collection and monitoring functions, if needed to ensure data continues to be collected nationally on abortion in New Zealand

34.2 establish a safe area around specific premises where abortion services are provided, on a case by case basis, where it is necessary to protect the safety and wellbeing, and privacy and dignity of, persons accessing or providing services at that facility.

### **Other instruments**

35 The Bill does not include any provision empowering the making of instruments other than regulations that are deemed to be legislative instruments or disallowable instruments (or both).

### **Definition of Minister/department**

36 The Bill does not contain a definition of Minister, department or equivalent government agency, or chief executive of a department or equivalent position.

### **Commencement of legislation**

37 The Bill will come into force on the day after Royal assent.

---

<sup>1</sup> Law Commission briefing paper, pages 208-209.

### Parliamentary stages

- 38 s9(2)(g)(ii) [REDACTED].
- 39 I propose the Bill be referred to a temporary Committee, established for the specific purpose of cross-party consideration of this Bill.

### Proactive Release

- 40 This paper will be proactively released when a bill is introduced to the House of Representatives.

RELEASED BY THE MINISTER OF JUSTICE

## Recommendations

41 The Minister of Justice recommends that the Committee:

- 1 **s9(2)(g)(ii)** ;
- 2 **note** that the Abortion Legislation Bill 2019 gives effect to the decisions made by Cabinet in May 2019 [SWC-19-MIN-0055 and CAB-19-MIN-0238 refers]
- 3 **note** that it is appropriate for the Contraception, Sterilisation, and Abortion Act 1977 to be binding on the Crown because there are obligations on the Crown and its purpose would be defeated if the Act did not bind the Crown;
- 4 **agree** that the Abortion Legislation Bill 2019 should include a provision stating that the Contraception, Sterilisation, and Abortion Act 1977 will bind the Crown;
- 5 **approve** the Abortion Legislation Bill 2019 for introduction, subject to the final approval of the government caucus and sufficient support in the House of Representatives;
- 6 **agree** that the Abortion Legislation Bill 2019 be introduced on the first available date after Cabinet approval;
- 7 **agree** that the Government propose that the Abortion Legislation Bill 2019 be:
  - 7.1 referred to a temporary Committee established for the specific purpose of cross-party consideration of this Bill; and
  - 7.2 **s9(2)(g)(ii)** .

Authorised for lodgement

Hon Andrew Little  
**Minister of Justice**





# Cabinet Legislation Committee

## Minute of Decision

*This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.*

### Abortion Legislation Bill: Approval for Introduction

Portfolio Justice

On 23 July 2019, the Cabinet Legislation Committee:

- 1 s9(2)(g)(ii)
- 2 **noted** that the Abortion Legislation Bill gives effect to the decisions made by Cabinet in May 2019 [SWC-19-MIN-0055];
- 3 **noted** that it is appropriate for the Contraception, Sterilisation, and Abortion Act 1977 to be binding on the Crown because there are obligations on the Crown and its purpose would be defeated if the Act did not bind the Crown;
- 4 **agreed** that the Abortion Legislation Bill should include a provision stating that the Contraception, Sterilisation, and Abortion Act 1977 will bind the Crown;
- 5 **approved** the Abortion Legislation Bill [PCO 21823/16.0] for introduction, subject to the final approval of the government caucuses and sufficient support in the House of Representatives;
- 6 **agreed** that the Abortion Legislation Bill be introduced on the first available date after Cabinet approval;
- 7 **agreed** that the government propose that the Abortion Legislation Bill be:
  - 7.1 referred to a temporary Committee established for the specific purpose of cross-party consideration of this Bill;
  - 7.2 s9(2)(g)(ii).

Vivien Meek  
Committee Secretary

Hard-copy distribution (see over)

**Present:**

Rt Hon Winston Peters  
Hon Chris Hipkins (Chair)  
Hon Andrew Little  
Hon David Parker  
Hon Stuart Nash  
Hon Kris Faafoi  
Hon Ron Mark (part item)  
Hon Tracey Martin  
Hon Julie Ann Genter  
Hon Eugenie Sage  
Michael Wood MP (Senior Government Whip)

**Officials present from:**

Officials Committee for LEG

**Hard-copy distribution:**

Minister of Justice

RELEASED BY THE MINISTER OF JUSTICE