

# Abortion law reform

Advising agencies	<i>Ministry of Justice</i>
Decision sought	<i>This analysis has been prepared to inform decisions by Cabinet in its consideration of the Law Commission’s briefing paper about options to take a health approach to abortion law.</i>
Proposing Ministers	<i>Minister of Justice</i>

## Summary: Problem and Proposed Approach

### Problem Definition

#### What problem or opportunity does this proposal seek to address? Why is Government intervention required?

Abortion in New Zealand is based in the criminal law. The Crimes Act 1961 sets out the circumstances when abortion is unlawful and the grounds for abortion. The Contraception, Sterilisation, and Abortion Act 1977 provides the procedural requirements for abortions, including who may authorise abortion, how women may access abortion services, the facilities where abortions may be performed, and by whom. The offence provisions in these Acts includes health practitioners. Women are covered by an offence in the Contraception, Sterilisation, and Abortion Act 1977.

The Minister of Justice requested advice from the Law Commission about options for the law if abortion was aligned with a health approach. The Law Commission’s briefing paper *Alternative Approaches to Abortion Law* was provided to the Minister of Justice on 26 October 2018.

The Minister of Justice indicated that he would like to propose reforms that decriminalised abortion, based on the Law Commission’s advice, through an amendment Bill presented to Parliament in early 2019.

There is no Government policy position on changing abortion law, with Cabinet agreement being sought for members to be permitted to oppose the amendment Bill or promote or support change to the Bill during the Parliamentary process. Changes to the policy settings for abortion law are traditionally treated as issues of conscience for members of Parliament. The Ministry has made assumptions about the likely main conscience issues and has treated these aspects in a value-neutral way, leaving members to decide which approach they prefer. Conscience issues are assumed to be the grounds for abortion and conscientious objection by health practitioners.

Other issues comprise the regulatory aspects of the proposals, which relate to access to services and the oversight of services. The current system affects the timeliness of abortions occurring, which can have negative health impacts, as can stigma, which is associated with criminalising abortion. There are also issues of barriers to access and inequities experienced by certain groups, such as Māori. The prescription in the legislation limits the ability to use developing medical technology, including within standards of practice.

### **Proposed Approach**

#### **How will Government intervention work to bring about the desired change? How is this the best option?**

Members will need to decide the approach they prefer for the conscience issues raised.

In terms of a regulatory framework, the proposed approach would regulate abortion services like other health services. This would result in existing health laws covering access to services, the licensing of premises, health practitioners' suitability to perform abortions, and the oversight of abortion services generally. The exceptions would be for statutory provisions for women to self-refer to services, and to ensure the availability of counselling.

Removing the existing legislative prescription and relying on existing health frameworks could help to prioritise the health and wellbeing of women considering abortion. It could also help to better ensure effective, timely and equitable access to abortion services over time.

## **Section B: Summary of Impacts**

### **Who are the main expected impacted parties and what is the nature of the expected impact?**

For the conscience issues, the Ministry of Justice has identified impacts on rights and freedoms, and any justified limitations on these, enshrined in the New Zealand Bill of Rights Act 1990. There are also impacts on New Zealand's international human rights obligations.

The Ministry of Health considered the impacts of the proposed regulatory framework on women and health practitioners. Women seeking an abortion could move through fewer process stages than the current system of referral by a doctor and approval by two certifying consultants. The Ministry of Health considers that there could be reductions in cost and stress for women seeking abortion services.

The Ministry of Health expects that overall the proposed regulatory approach would be fiscally neutral for the government. There will be low one-off costs for the Ministry of Health, District Health Boards, regulatory authorities and professional training bodies, and minor ongoing costs for these parties.

### **What are the likely risks and unintended impacts, how significant are they and how will they be minimised or mitigated?**

There may be some uncertainty from health practitioners about the new aspects of the system. Transitional arrangements will be required to maintain the quality and capacity of abortion services during the implementation phase of the proposed changes.

### **Identify any significant incompatibility with the Government's 'Expectations for the design of regulatory systems'.**

None identified.

## Section C: Evidence certainty and quality assurance

### Agency rating of evidence certainty?

This Regulatory Impact Statement reflects advice from the Law Commission to the Minister of Justice. The Ministry of Justice considers that the advice of the Law Commission covers the relevant issues and is sound. However, the Ministry notes that there is limited evidence on which to understand the impact of the current abortion law on women and health practitioners, for example, on timeliness and access to services, or the level of stigma these groups may experience.

*To be completed by quality assurers:*

### Quality Assurance Reviewing Agency:

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.

### Quality Assurance Assessment:

Overall, the Panel considers that the RIA meets the Quality Assurance criteria, with one note:

### Reviewer Comments and Recommendations:

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.

# Impact Statement: Abortion law reform

## Section 1: General information

### Purpose

The Ministry of Justice is responsible for the analysis and advice set out in this Regulatory Impact Statement, except as otherwise explicitly indicated (the statement reflects advice from the Law Commission to the Minister of Justice, and the Ministry of Health provides some parts of the analysis). This analysis and advice has been produced to inform:

- key (or in-principle) policy decisions to be taken by or behalf of Cabinet, which will provide the contents of an amendment Bill to be presented to Parliament
- members of Parliament about the impact of the amendment Bill.

### Key Limitations or Constraints on Analysis

#### Likely conscience issues for members of Parliament

##### *Officials' role in providing advice on conscience issues is limited*

- All policy decisions involve applying ethical and value-based judgments. These values are normally reflected through the objectives section of a regulatory impact statement, with the objectives typically set by the Government.
- There is no Government policy position on changing abortion law. The proposal is for Cabinet to agree that members be permitted to oppose the amendment Bill or to promote or support change to the Bill during the Parliamentary process.
- Traditionally abortion raises issues of conscience for decision-makers when considering the policy settings for the legislation. It is anticipated that Parliament will treat aspects of the proposed reforms as conscience issues. The Ministry has assumed that the likely main conscience issues would be the lawful grounds for abortion and conscientious objection.
- To support members of Parliament to make their own judgments, these two issues are treated in a value-neutral way in this Regulatory Impact Statement. The Ministry has highlighted factors decision-makers could weigh when considering options, rather than explicitly assessing options against any objectives, leaving decision-makers to decide which approach they prefer.
- While the likely conscience issues are treated neutrally, the design of the proposed regulatory system underpinning the lawful grounds for abortion has been informed by objectives developed by the Ministry based on a 'health approach'. Individual features that could make up a regulatory system are assessed against the objectives set out in section 2.4.

#### Limited scope for options

##### *The Minister of Justice asked for options from the Law Commission*

- The Minister of Justice requested advice from the Law Commission about options for the law if abortion was aligned with a health approach. The Ministry's analysis is based wholly on the scope of the request and the Law Commission's subsequent advice, which has provided the basis for the scoping of the problem, evidence and the options considered.
- The Ministry has applied an options analysis to the features of the regulatory system, which are access and oversight of abortion services, and informed consent and counselling. The analysis is focused on the Law Commission's proposals for the system. The Ministry has analysed these features and considered whether there are any gaps in this system.

- The Ministry provides an analysis of the options for the criminal offences and other accountability mechanisms and safeguards proposed for the regulatory system.
- The Ministry was asked for advice on options for introducing safe access zones and this analysis is provided.

#### Limited evidence base

*There is a lack of data of how the current system affects those engaging with it*

- There is limited data about the impact of the status quo on different groups (i.e. women, health practitioners), except for anecdotal evidence. For example, data on timeliness, access to services, and the level of stigma experienced by these groups.
- There is no New Zealand data available on the impact on women accessing abortion services of the behaviour around these services of anti-abortion groups or individuals. The information relied upon in the analysis was that gathered by the Law Commission.

#### Timing and consultation

*Ministerial priorities limit opportunity for further consultation, additional to the Law Commission process*

- The Minister of Justice has indicated that his priority is for an amendment bill to be introduced and considered by Parliament in 2019.
- The Law Commission undertook a public process in the development of its briefing paper that involved public submissions and meetings with stakeholders from the health sector.
- To achieve the legislative time frame no further wide consultation has been undertaken. There will be consultation on the proposed Bill at select committee stage.

#### **Responsible Manager:**

*[Name withheld under section 9(2)(a) of the Official Information Act 1982]*

Policy Group, Ministry of Justice  
17 May 2019

## Section 2: Problem definition and objectives

### 2.1 What is the context within which action is proposed?

Abortion in New Zealand is based in the criminal law. Actions relating to procuring or providing abortions are offences under two statutes: the Crimes Act 1961 (Crimes Act); and the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act). The CSA Act establishes processes for performing lawful abortions and, in relation to abortion, is virtually unchanged from when it was enacted.

The Minister of Justice asked the Law Commission in February 2018 to provide advice on alternative approaches that could be taken in our legal framework to align with a health approach. Specifically, this included reviewing the criminal aspects of abortion law, and the statutory grounds for an abortion and process for receiving services.

The Law Commission is an Independent Crown Entity that reviews, reforms and develops New Zealand law and provides advice and recommendations to the Government on reforms.

The Law Commission's briefing paper *Alternative Approaches to Abortion Law* was provided to the Minister of Justice on 26 October 2018.

The Law Commission's briefing paper covers the options for the key areas of abortion law:

- the lawful grounds for abortion
- access to abortion services (including referrals, licensing of facilities, and performing abortions)
- oversight of abortion services
- informed consent and counselling
- conscientious objection by health practitioners, and
- criminal aspects of abortion.

The issue of safe access zones was also raised in the briefing paper as a topic for possible further consideration by the Government. Some jurisdictions have introduced these zones, which apply within a specified radius of an abortion facility, to protect women entering an abortion facility from intimidating behaviour.

#### **Abortion statistics**

About 13,000 women in New Zealand have an abortion every year (13,285 in the year ended December 2017, or 13.7 abortions per 1,000 women aged 15-44 years). Abortion rates have fallen since 2007, when the rate was 18,382, or 20.1 abortions per 1,000 women aged 15-44 years.<sup>i</sup>

In 2017 89.4 per cent of abortions occurred in the first trimester (12 weeks, 6 days) of pregnancy. A further 8.3 per cent of abortions occurred in weeks 13-16, 1.7 per cent occurred between 17-20 weeks and 0.5 per cent after 20 weeks.<sup>ii</sup>

## 2.2 What regulatory system, or systems, are already in place?

Abortion is regulated under the Crimes Act and CSA Act, which overlays the general regulatory framework for health services in New Zealand. The specific features of the current system are set out in Section 3 of this Regulatory Impact Statement (RIS).

### General context of New Zealand's public health regulatory framework

Our health system's regulatory framework has the purpose of achieving a range of objectives for the public health care system in New Zealand. The NZ Public Health and Disability Act 2000 provides for the public funding and provision of personal health services, public health services, and disability support services. Section 3 of that Act provides that the objectives in providing these services include the improvement, promotion, and protection of New Zealanders' health, the best care or support for those in need of services, as well as reducing health disparities by improving the health outcomes of Māori and other population groups.

## 2.3 What is the policy problem or opportunity?

The Minister of Justice asked the Law Commission, as an Independent Crown entity, to provide advice on what treating abortion as a health matter could look like. From a health perspective, the current approach of abortion law has some of the following impacts.

### Timeliness

In New Zealand 59 per cent of abortions in 2017 occurred before the tenth week of pregnancy. This is significantly lower than in many comparable countries. For example, in England and Wales in 2017, 77 per cent of abortions were carried out before 10 weeks.<sup>iii</sup>

Abortion is a highly time-sensitive process. Timeliness is therefore a particularly relevant consideration for the health of pregnant people considering an abortion.

A New Zealand study on timeliness of first trimester abortion services in 2010 concluded there are lengthy delays in accessing services. There was an average wait of 25 days between the first appointment with referring doctor and having the procedure with more than half the women involved in the study having terminations at more than 10 weeks (post-first trimester).<sup>iv</sup>

Using the data from the same study above to identify the factors that cause delay, a further New Zealand study in 2011 concluded the contributing factors are whether women accessed services via a private clinic (fewer delays) or public clinic (more delays); the number of visits with a referring doctor (more visits meant greater delay); and the stage of pregnancy (women who accessed services earlier in pregnancy experience longer delays). The study noted that individual decision-making (e.g. timing of decision to have an abortion) had no significant effect on delays.<sup>v</sup>

Delay can increase the risk of adverse health outcomes (because earlier abortions are less intrusive/invasive and safer than later ones), increase the levels of distress for the pregnant person and the health practitioners involved,<sup>vi</sup> or result in an abortion not being obtained at all.

### Stigma

Offences aim to punish, deter and publicly denounce conduct that society considers to be blameworthy and harmful.<sup>vii</sup> Criminalisation can create stigma for people who are considering an abortion and may increase the risk to their mental health and well-being. Health practitioners who provide abortion services also face the prospect of potential criminal prosecution and may feel stigmatised. This stigma could reduce the number of practitioners willing to train and provide services and have a subsequent impact on the availability of services.<sup>viii</sup>

## Access and equity

The Law Commission notes the concerns about the disproportionate impact that barriers to access have on Māori.<sup>ix</sup> Research used by the Law Commission indicates that Māori adults are more likely to have an unmet need for a General Practitioner or after-hours health service due to barriers to access such as cost, lack of transport, lack of childcare and being unable to get to a medical centre.

Submitters to the Law Commission stated that in areas with high Māori populations there is limited access to reproductive and contraceptive health services and information generally.

A 2016 study, cited by the Law Commission, found that young Māori women have significant difficulty accessing reproductive health services. The research found that access to reproductive health services can be “fraught with stigma, embarrassment, a lack of information and limited access to culturally appropriate services.”

A study on geographic access to services in 2008 determined that more than one-sixth of New Zealand women have difficulty accessing services due to lack of services in their region and are required to travel long distances to access services elsewhere (on average 221km one way). It was also noted that three of the five regions where abortion services were not available had a higher than average percentage of Māori population within those regions.

The authors conclude, in the context of Māori women having to travel long distances to access services, that difficulties in access potentially make the experience of seeking an abortion more stressful and also highlight existing inequalities experienced by this population group.<sup>x</sup>

## Standards of practice

The legislative process for abortions was enacted more than 40 years ago, and aspects are now inconsistent with modern medical practice for abortions. For example, the CSA Act was enacted before the availability of medications to address early abortions and envisages only surgical abortions that must be carried out by a doctor in licensed premises. Nor does it consider medication that can be safely taken at home. In the year ending December 2017, 20.56 per cent of abortions were medical only (no surgery).<sup>xi</sup>

The Abortion Supervisory Committee’s *Standards of Care for women requesting abortion in Aotearoa New Zealand* (2018) recognise that there have been significant changes in healthcare delivery and medical technologies since the law was enacted.<sup>xii</sup> The legislation inhibits these developments flowing through to the delivery of services. It also does not support services meeting international standards of best practice.

## 2.4 What are the objectives of the proposed regulatory intervention?

### Conscience issues

Traditionally abortion raises issues of conscience for members of Parliament when considering the policy settings for the legislation, where members are permitted to exercise a personal vote rather than according to their party’s policy position. Conscience matters are generally issues that relate to wider societal values that may be strongly contested.

The Ministry anticipates that Parliament will treat aspects of the proposed reforms as conscience issues, and has assumed these to be:

- the lawful grounds for abortion, and
- conscientious objection.

To support members of Parliament to make their own judgments, these two issues are treated in a value-neutral way. Section 3 of this RIS highlights factors decision-makers could weigh when considering options, rather than explicitly assessing options against any objectives, leaving decision-makers to decide which approach they prefer.

### **Regulatory framework issues**

While this RIS treats conscience issues neutrally, objectives are required to guide the design of an alternative regulatory system governing access to abortion services (including referrals, licensing of facilities, and performing abortions), and providing for oversight of abortion services.

To understand a health approach to abortion, the Law Commission examined how the law deals with other health services, including drawing from general laws and professional standards relating to health services.<sup>xiii</sup>

The overall objectives for the alternative regulatory system are that it:

- prioritises the health and wellbeing of the individual patient and their autonomy to make an informed decision;
- ensures effective, timely and equitable access to health services; and
- enables continuous improvement of the quality of services.

Section 3 of this RIS provides criteria for the proposed regulatory system that contribute to achieving the overall objectives.

## **2.5 Are there any constraints on the scope for decision making?**

The analysis is based on the scope of the Law Commission's briefing paper and the options presented, which was requested by the Minister of Justice on the matter of abortion law reform.

### **Interdependencies or connections to other work**

Access to contraception is an important consideration in reproductive health and is closely connected to abortion. There has been an extension to funding for contraceptive services for low income women. The services will comprise free long-acting reversible contraception insertions and removals, and a capped number of low cost consultations. The Ministry of Health is developing a Sexual and Reproductive Health Action Plan that includes the issue of access to contraception.

The Ministry of Health is undertaking policy work on the issue of non-consensual sterilisation as part of the New Zealand Disability Action Plan. The issue of non-consensual sterilisation is closely linked to the issue of non-consensual abortion, particularly as the sterilisation procedure may be performed at the same time as an abortion procedure where the person is deemed not competent to consent to the abortion.

The Ministry of Health is also seeking feedback on the draft Therapeutic Products Bill, which would replace the Medicines Act 1981 and establish a new regulatory scheme for therapeutic products. This includes medicines (including cell and tissue products) and medical devices.

Other work connected to abortion law reform is the review of New Zealand's health and disability system, due to report back by 31 March 2020. The focus of the review is to ensure recommendations are made which will improve equity of outcomes. The review is expected to also highlight system challenges, pressure and demands. Abortion services in the future could reflect any system changes resulting from the review.

## 2.6 What do stakeholders think?

There is a wide variety of interested individuals and groups with differing ethical and value-based judgments about abortion law.

For the regulatory system aspects, the primary stakeholders are pregnant people who may be considering an abortion. Other major stakeholders are health professionals who provide abortion services.

In developing its briefing paper, the Law Commission ran a consultation process in two parts. The first part was consultation with health professionals and relevant statutory bodies. The second part was inviting submissions from the public.

The Law Commission received 3,419 submissions. Of the total submissions received, 61 were from organisations such as government bodies, professional organisations, academic groups, religious organisations and interest groups. A further four submissions were made by peer groups within professions. The remaining 3,354 submissions were from people speaking in their personal capacity.

The Law Commission noted that although 3,419 submissions were received, this does not mean 3,419 separate viewpoints were expressed. Some submitters made duplicate or follow up submissions which were recorded as separate submissions.

### **Submissions from the general public**

A significant number of the 3,354 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.

Submissions varied considerably in their complexity and the number of issues they addressed. Some addressed many issues potentially raised by the decriminalisation of abortion and its treatment as a health issue. Others addressed a single issue. Most addressed those issues of concern to the submitter. Some submitters simply shared personal stories without stating their wider views. Almost half of all submitters expressly stated their opposition to the decriminalisation of abortion.<sup>xiv</sup>

### **Consultation with health professionals and statutory bodies**

The Commission met with bodies representing various professions (general practitioners (GPs), obstetricians and gynaecologists, nurses, midwives, social workers, and counsellors).

The Commission met with organisations that provide abortion services or represent health professionals involved in abortion care (such as Family Planning New Zealand and the Abortion Providers Group Aotearoa New Zealand (APGANZ)).

The Commission also met with relevant statutory entities and health regulatory bodies, most notably the Abortion Supervisory Committee (ASC), the Health and Disability Commissioner, and the Medical Council of New Zealand.

Health organisations with a specifically Māori orientation were included in this consultation. These included Ngā Māia Māori Midwives Aotearoa; Te Whāriki Takapou (formerly Te Puāwai Tapu, a kaupapa Māori organisation providing Māori sexual and reproductive health promotion and research services); as well as the kaiwhakahaere for the New Zealand Nurses Organisation.

The Ministry of Health also surveyed all district health boards (DHBs) about the provision of abortion services, using questions provided by the Commission.

The Ministry of Health hosted a meeting with representatives of health professional bodies and

abortion service providers when proposals were being formulated by the Law Commission.

The Commission also held a discussion with its Māori Liaison Committee.

Health practitioners and professional bodies the Commission consulted were almost unanimous in supporting Model A. They considered it would be most consistent with a health approach, because it would make abortion a matter between a woman and her health practitioner.

## Section 3: Options, criteria and analysis

### 3.1 Approach to the options, criteria and analysis

The Law Commission's briefing paper options, together with a summary of the Commission's main rationale for its proposed option, are described in this section. The section also covers any proposed modification to a Law Commission option.

The Ministry of Justice considers that the Law Commission's advice canvassed the relevant factors and identified appropriate considerations in presenting its options.

The Commission considered the experience of other countries in reforming their abortion laws, as well as the views gathered during its consultation period.

### 3.2 Lawful grounds for abortion (conscience issue)

#### Status quo

The Crimes Act sets out the circumstances when abortion is unlawful. "Unlawfully" means the person performing the abortion does not believe one of the grounds for abortion set out in section 187A applies. In this section the grounds for abortion for pregnancies of up to 20 weeks' gestation are:

- serious danger to the woman's life or physical or mental health
- substantial risk that the child would be seriously handicapped
- pregnancy caused by incest or sexual intercourse with a dependent family member
- the woman is "severely subnormal".

After 20 weeks' gestation, the abortion must be necessary to save the woman's life or prevent serious permanent injury to her physical or mental health (section 187A(3)).

The procedural requirements for abortions are in the CSA Act (section 32). The CSA Act requires two certifying consultants to certify that grounds for an abortion under section 187A of the Crimes Act apply to authorise the performance of an abortion (sections 29 and 33). Certifying consultants are appointed by the Abortion Supervisory Committee (see below) (section 30). At least one of the two approving consultants must be a practising obstetrician or gynaecologist (section 32). If one of the consultants does not approve, another certifying consultant can be consulted (section 33).

#### Options

The Law Commission says treating abortion as a health issue calls into question the need for specific abortion legislation, since the existing health regulatory framework already applies to all health services. Most health services are not subject to their own legislative regime and are instead governed by this general health regulatory framework (described in Section 2 above).

The Commission was, however, asked to provide advice on a range of alternative approaches and,

in its briefing outlines three models, A to C. The Commission explains that for its models, Model A contemplates no specific abortion legislation, while Models B and C would retain a specific statutory regime for abortion, although both would be significantly simpler than the current regime. The Commission considers that all three models would give greater priority to the health and wellbeing of the woman seeking an abortion than the current law.

All the options are based on repealing the current grounds for abortion in section 187A of the Crimes Act and repealing the procedural requirements for abortions, including authorisation by two certifying consultants.

#### 1) *Model A*

Model A has no statutory test that must be satisfied before an abortion could be performed. The decision whether to have an abortion would be made by a woman in consultation with her health practitioner(s). General health law would apply to ensure services are provided safely and in line with best practice.

The Law Commission's key comments about Model A are that it:

- Prioritises women's autonomy to make an informed decision about what is appropriate for them in the circumstances. It would treat the women as fully competent to weigh the competing considerations involved in the abortion decision, with support from health practitioners and other support services where appropriate.
- Aligns with the principles that underlie the provision of health services generally, as set out in health regulatory laws and the codes of ethics that apply to health practitioners.
- Treats abortion in the same way as most other health services, which are not restricted by statutory criteria and do not require legal authorisation.
- Is similar to the law in Canada and the Australian Capital Territory. In both these jurisdictions abortions can lawfully be performed at any gestation without needing to satisfy any statutory grounds.

#### 2) *Model B*

Model B would have a statutory test set out in the CSA Act rather than the Crimes Act 1961. The test would be that the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.

Law Commission's key comments about Model B are that it:

- Contains the most significant statutory restrictions on abortion of the three models, because it would apply at all gestations. It would require an appropriately qualified health practitioner to be satisfied that a statutory test for abortion is met.
- Directs the health practitioner to consider whether the abortion is appropriate, rather than setting out specific circumstances in which abortions can be lawfully performed. This means the assessment would be made from a health perspective, rather than a legal one.
- Leaves significant discretion to health practitioners to have regard to all the circumstances of an individual case. However, the test does require the health practitioner to have regard to a woman's physical and mental health and wellbeing.
- Provides some continuity with the "serious danger to physical and mental health" ground in the current 187A of the Crimes Act, which health practitioners are already accustomed to. The Law Commission has noted that the removal of the "serious danger" requirement and the new reference to "wellbeing" would make it clear that a broader assessment of health and

wellbeing is envisaged.

- The requirement for the abortion to be “appropriate in the circumstances” is similar to wording found in the laws of Victoria and Northern Territory (although in Victoria the requirement only applies to abortions after 24 weeks gestation). However, none of the jurisdictions examined by the Commission that have reformed their abortion laws have adopted an approach similar to Model B (applying the same statutory test for all gestations).

### 3) *Model C*

Model C would have no statutory test that must be satisfied before an abortion could be performed for pregnancies of not more than 22 weeks gestation. The decision whether to have an abortion would be made by a woman in consultation with her health practitioner(s).

For pregnancies of more than 22 weeks gestation, there would be a statutory test in the CSA Act rather than the Crimes Act 1961. The test would be that the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman’s physical and mental health and wellbeing.

Law Commission’s key comments about Model C are that:

- Adopting a gestational limit would reflect a view that both the abortion procedure and the reasons an abortion is sought can be increasingly complex the further the pregnancy progresses. The Commission identified several reasons why increased legal oversight may be considered appropriate for abortions at later gestations:
  - the abortion procedure is different for late term abortions
  - late term abortions have more severe side effects and higher rates of complications
  - some consider that the interest in preserving the life of the fetus increases as the fetus develops.
- A gestational limit of 22 weeks suggests as at a point where a fetus is unlikely to be “viable”.
- Abortion law in several other jurisdictions includes a gestational limit. For example, laws in Tasmania impose no statutory restrictions for abortion before 16 weeks. Laws in Victoria impose no statutory restrictions for abortion before 24 weeks. After the gestational limit the law limits abortion to certain circumstances in both jurisdictions.

### 4) *Model C with alternative gestational limit of 20 weeks*

The proposal for the amendment Bill is for a modified Model C, which includes a lower gestational limit of 20 weeks. As noted above, the current Crimes Act provision has different grounds for abortion for pregnancies of up to 20 weeks, and after 20 weeks’ gestation.

The Law Commission did not specifically discuss a 20 weeks’ gestational limit.

#### **Impacts**

This analysis only describes the legal factors decision-makers may need to weigh when determining the public policy settings for access to abortion and conscientious objection by health practitioners. Additional ethical or moral considerations will also inform conscience matters.

#### *Legal factors*

When considering the options, human rights law is relevant because legislation should be consistent with the New Zealand Bill of Rights Act 1990 (NZBORA) and our international obligations. The Law Commission’s comments on submitters’ views are also broadly summarised in the analysis.

## New Zealand Bill of Rights Act 1990

NZBORA provides, among other things, that:

- no one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice (section 8)
- everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment (section 9)
- everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference (section 13)
- everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993 (section 19). In the Human Rights Act prohibited grounds of discrimination include sex (including pregnancy) and disability.

Rights and freedoms may only be subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society (section 5). 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.

## International human rights and abortion law

New Zealand has ratified seven core international human rights treaties, and each treaty requires New Zealand to submit periodic reports to a committee of independent experts at the United Nations (UN) (treaty body) about how we are meeting our obligations. The relevant treaty body examines the report, which includes meeting with a delegation from New Zealand at the UN in Geneva. The treaty body then issues concluding observations which note positive developments and make recommendations. New Zealand must report on how it has implemented the recommendations in its next report (generally 5 years later) or earlier if requested by the treaty body.

While no international convention or treaty explicitly refers to abortion, some UN conventions and treaties that New Zealand has ratified contain related provisions.

The provisions and treaty body recommendations relating to abortion and reproductive rights for these conventions (either in general or directed at New Zealand) are noted below.

Broadly speaking, the recommendations are for New Zealand to reform its abortion law to better comply with international human rights obligations.

### *Universal Periodic Review of New Zealand*

New Zealand's third Universal Periodic Review at the United Nations Human Rights Council in Geneva was held on 21 January 2019. The Universal Periodic Review considers New Zealand's human rights records over the last five years. The Government has yet to respond to the recommendations made during the 2019 review.

- Recommendations to New Zealand - In 2019, the Universal Periodic Review Working Group members made recommendations on abortion.  
  
Remove abortion from the Crimes Act and amend the CSA Act so abortion is decriminalised and implement recommendation "Model A" from the Law Commission's report (Iceland).  
  
Remove abortion from the Crimes Act and review the CSA Act to ensure that abortion is decriminalised in all circumstances, and all women and girls can access safe and legal abortion as an integrated component of sexual and reproductive health services, in reference also to the adoption of SDG target 3.7 and 5.6 (Netherlands).

Eliminate, in accordance with the recommendation by CEDAW, abortion from the Crimes Act and amend the CSA Act in order to completely decriminalise abortion by amending legislation through the implementation of Recommendation A of the Legal Committee on “alternative approaches to the Law on Abortion” (Uruguay).

Reform the law on abortion and take a human rights-based approach by implementing Model ‘A’ from the Law Commission report (Canada).

#### *Convention on the Elimination of Discrimination Against Women (CEDAW)*

- General recommendation/comment - In 1999, the CEDAW Committee clarified that access to health care, including reproductive health, is a basic right under CEDAW.
- Recommendations to New Zealand - In 2012, the Committee recommended New Zealand review its abortion law and practice with a view to simplifying and ensuring women’s autonomy.

In 2018, the Committee recommended the removal of abortion from the Crimes Act 1961 and to amend the Contraception, Sterilisation and Abortion Act 1977 to fully decriminalise abortion and incorporate it into health legislation.

In 2018, the Committee also recommended New Zealand legalise abortion in cases of rape, incest, threats to life or health of the pregnant woman, or severe fetal impairment. Also, to ensure access to safe abortion and post-abortion care and services.

#### *International Covenant on Civil and Political Rights (ICCPR)*

- General recommendation/comment - The UN Human Rights Committee noted that the right to life does not affirm the right to life of the unborn. Rather it expressly supports the right to life of pregnant women and access to abortion services.

The Committee confirmed that the right to privacy includes autonomy over one’s body (2014).

#### *International Covenant on Economic, Social and Cultural Rights (ICESCR)*

- General recommendation/comment - In 2000, the Committee on ICESCR stated that the right to sexual and reproductive health is an integral part of the right to health enshrined in ICESCR.

#### *Convention on the Rights of the Child (UNCROC)*

*The preamble states "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth"*

- General recommendation/comment – In 2013, the Committee on UNCROC recommended that all states ensure access to safe abortion and post-abortion care services regardless of legality of abortion.

In 2016, the Committee stated that voluntary and informed consent of young people should be obtained whether or not consent of parent or guardian is required for any medical treatment or procedure. There should also be a legal presumption that young people are competent to seek and access sexual and reproductive health services.

#### *Convention on Rights of People with Disabilities (CRPD)*

- General comment - In 2018, the Committee on CRPD, jointly with the Committee on CEDAW, stated that all states should decriminalize abortion in all circumstances and legalise it in a manner that fully respects the autonomy of women, including women with disabilities. It called on states to take a human rights-based approach that safeguards the reproductive choice

and autonomy of all women, including women with disabilities.

In 2017, the Committee on CRPD stated that laws that explicitly allow abortion on the grounds of fetal impairment violate articles 4, 5 and 8 of the CRPD.

### Domestic human rights law

For context, New Zealand's current domestic human rights law settings show:

- The High Court has found that there is nothing on which to base a right to abortion for women under the NZBORA, unlike what has been found in other jurisdictions (as these are based on constitutional guarantees).
- The Court of Appeal has held there is no legislative basis in the CSA Act to derive generally an express right to life of the unborn child. In New Zealand the common law "born alive" rule applies, which means that there are generally no legal rights recognised until a child is born alive. The Supreme Court has said the current CSA Act is based on this premise. The Royal Commission of Inquiry that led to the CSA Act intended to give weight to the interests of both the woman and the fetus in its report.

### *NZBORA and justified limitations*

For lawful grounds for abortion, the relevant NZBORA rights include freedom of discrimination on the basis of sex. The key consideration for decision-makers in relation to considering the grounds is likely to be whether any of the restrictions in the Models (if present) impairs these rights no more than reasonably necessary and is proportionate to the importance of the objective.

We infer from the Law Commission's comments that:

- Model A's objective is to align with principles that underlie the provision of health services generally
- Model B's objective is to prioritise women's health and wellbeing while providing the health practitioner with the final decision-making power
- Model C's objective is to provide legal oversight for the complexity of later gestation pregnancies.

### **Submitters' views to the Law Commission**

#### Model A

Health sector representatives' views to the Law Commission were almost unanimous in support of Model A because it was most consistent with a health approach. Other views in support of Model A were that it would treat abortion like other health services and make it safer and more accessible.

The Law Commission says that many members of the public submitted that abortion is different to other health services because it involves ending the life of a fetus, and therefore it is appropriate to have specific laws governing it. Model A would not address societal concerns about protecting the life of a fetus through a legal framework.

#### Model B

For Model B, many health practitioners emphasised to the Law Commission that listing the specific circumstances in which abortions can be performed in statute can result in injustice. Some health practitioners and submitters suggested the statutory test would prompt the health practitioner to have a discussion with the woman about her reasons for seeking an abortion, which may in itself be of assistance to some women. It would provide an opportunity for women to disclose concerns around violence or coercion and access further support if they want it. A small number of individual health practitioners the Commission spoke to saw some value in retaining a statutory test for this

reason.

Some health practitioners the Commission spoke to questioned why they should be the ones to assess whether abortion is in the best interests of the woman. They considered the woman is in the best position to assess what is right for her in her individual circumstances. The health practitioner who will perform the abortion will often have just met the woman and may not have a thorough appreciation of her circumstances. A number of submitters expressed similar views.

Most health practitioners and professional bodies considered the informed consent requirements that exist under general health law are sufficient to ensure women have an opportunity to discuss concerns or access further support.

### Model C

For Model C, some submitters to the Law Commission expressed the view that when a fetus has reached an advanced stage of development, there should be limits on the availability of abortion. Some submitters and commentators suggest that the relevant gestational stage should be the point at which the fetus becomes “viable” (in this context, viability refers to the ability of the fetus to live independently if born prematurely).

Most health practitioners and professional bodies the Commission consulted did not support Model C. Most health practitioners felt the law should not limit the circumstances in which a woman may have a lawful abortion later in pregnancy.

A small number of health practitioners saw some advantages in a model that incorporated a gestational limit, like Model C. When a pregnancy is normal and there are no medical indications for the abortion, legal grounds for late term abortions provide a basis for declining an abortion that is considered inappropriate by the health practitioner involved.

Several health professionals stressed to the Commission that viability cannot be accurately reflected by a single watershed moment in a pregnancy. However, some health professional bodies and practitioners agreed that 22 weeks gestation was the best marker of viability.

Some health practitioners who opposed Model C pointed out that several significant conditions affecting a pregnancy and the health of the mother could arise after the gestational limit. They suggested it would be unwise to restrict abortion when these conditions may arise.

### General submitter comments on a statutory test

The Law Commission’s summary of submissions states that a significant number of submitters did not express a preferred model, but instead argued that various criteria in the current statutory test are inappropriate, either because they are too restrictive or not restrictive enough.

The Law Commission notes that submitters had mixed views as to whether the law needs to provide a statutory test for when an abortion should be lawful. Many submitters supported the current law under which there is a statutory test. Many others thought there should be no test. Some thought that a test should only apply after a certain point in gestation (a “gestational limit”). A few thought that a different test should apply at different stages of the pregnancy, similar to the current law.

### 3.3 Conscientious objection of health practitioners (conscience issue)

#### Status quo

Under the CSA Act no person is obliged to perform or assist in an abortion if they object to doing so on grounds of conscience (section 46). Under the Health Practitioners Competence Assurance Act 2003 there can be a conscientious objection raised by a practitioner, and if so, they must inform the person that they can obtain the service from another health practitioner (section 174) (but do not have to refer the person to another service).

#### Options

The Law Commission considers setting out the obligations of practitioners in legislation was preferable in the area of conscientious objection, because legislation is a strong means of imposing duties on practitioners, provides clarity on the duties, and avoids disputes that may occur if objections were only dealt with in professional standards and guidelines.

The Commission said changing the law could be considered to ensure conscientious objection does not unduly delay women's access to abortion services.

The two options are either:

- a. Option 1 (status quo): Maintain the current law regarding conscientious objection, or
- b. Option 2: if a health practitioner objects to any aspect of abortion service on the grounds of conscience, the health practitioner would be required, as soon as reasonably practicable, to:
  - i. disclose the fact of their objection to the woman; and
  - ii. refer the woman to another health practitioner or abortion service provider that can provide the service.

#### Impacts

As with section 3.2 above, this analysis only describes the legal factors decision-makers may need to weigh when determining the public policy settings for conscientious objection by health practitioners. Additional ethical or moral considerations will also inform conscience matters.

#### *NZBORA and justified limitations*

For conscientious objection, the relevant NZBORA rights include freedom of thought, conscience, religion and belief. The key consideration for decision-makers in relation to restricting a health practitioner's ability to conscientiously object is likely to be whether the restriction impairs the right no more than reasonably necessary and is proportionate to the importance of the objective.

As articulated by the Law Commission, the objective is to ensure that conscientious objection does not unduly delay women's access to abortion services.

The Law Commission notes that the limitations should be considered in the context of broader proposed reforms, as other changes to the legislative regime included in its advice may reduce the access issues related to doctors exercising conscientious objections. For example, enabling women to access abortion services directly through self-referral may reduce the impact of conscientious objections.

#### Submitters' views to the Law Commission

Submitters to the Law Commission stated that practitioners who refuse to refer women to abortion service providers based on conscientious objection can create difficulties for women. District Health Boards advise that practitioners refusing to provide services inevitably cause delays to women, as

they must find another practitioner and make another appointment. Submitters noted that unless the practitioner who objects tries to refer the woman to another doctor, there can be delays, particularly for vulnerable women who may struggle to navigate the system without assistance. Some submitters also noted that it can impede access to services in smaller or remote communities, because women may have to travel to see a practitioner without an objection.

Other submitters supported the retention of existing provisions for conscientious objection, noting that is important for practitioners to work according to their conscience and that no person should be compelled to play any part in the abortion process.

### **Implications for health staff who aren't health practitioners**

The Health Practitioners Competence Assurance Act 2003 (HPCA Act) relates only to health practitioners. The CSA Act states that a medical practitioner, nurse, or any other person can invoke conscientious objection. The Law Commission recognises that women seeking abortions or advice in relation to abortion do not rely on administrative staff in the same way as they do health practitioners, and that conscientious objections held by administrative staff are less likely to affect access to abortions.

### **Interaction with other areas of sexual reproductive health**

The provisions on conscientious objection in both the HPCA Act and the CSA Act apply to all reproductive health services, not only abortion, and also to contraception and sterilisation.

## **3.4 Regulation of abortion services (access and oversight of services)**

### **Status quo**

A diagram setting out the current process for women considering an abortion is attached to this statement.

#### *Referrals to services*

The CSA Act prescribes that a woman needs to be referred to a certifying consultant by a doctor (rather than other kinds of health practitioners such as nurses or midwives) (section 32).

#### *Licensing of facilities*

The CSA Act establishes the Abortion Supervisory Committee, which is the oversight body for the operation of abortion law under the Act, comprising three members appointed by the Governor-General on the recommendation of the House of Representatives (sections 10 and 14).

The Abortion Supervisory Committee has a range of statutory functions, including considering hospital, clinic, or other premises licence applications to perform abortions, and ensuring that hospitals, clinics and other premises with abortion licences have adequate facilities (section 14). Abortions can only be performed in a facility licensed by the Committee (section 18).

Two other statutes are relevant to abortion health care facilities. The Health and Safety at Work Act 2015 sets out principles, duties and rights in relation to workplace safety that apply to all facilities, including hospitals, medical centres and sexual health services. For hospitals, the Health and Disability Services (Safety) Act 2001 requires hospital services to meet standards of care (demonstrated through audits) and be certified by the Director-General of Health.

#### *Performing abortions*

Abortions may be surgical or medical (which are abortions performed by the administration of medicine). Under the CSA Act an abortion can only be performed by a "doctor" (i.e. a medical practitioner), who is referred to as the 'operating surgeon' (section 32). The CSA Act was enacted

prior to the established use of medical abortions.

Health practitioners that perform abortions are covered by the Health Practitioners Competence Assurance Act 2003, which aims to protect the safety of the public by providing mechanisms to ensure the competence of health practitioners. Regulatory aspects that apply include:

- all practitioners must operate within their particular scopes of practice
- requirements for annual practising certificate
- certain activities can be restricted for individual practitioners
- a duty on practitioners who object on the grounds of conscience.

Medicines, related products and medical devices used to perform abortions are regulated under the Medicines Act 1981, which includes rules around prescribing and dispensing medication. In addition, the Health Practitioners Competence Assurance Act 2003 means that a health practitioner's scope of practice also determines their ability to prescribe certain medications. It also allows for practitioners to be prohibited from prescribing specific classes of medications.

#### *Oversight of abortion services*

Under the CSA Act, as well as appointing certifying consultants and licensing facilities, the Abortion Supervisory Committee must keep abortion law under review, and the operation and effect of those laws in practice. It must also collect, analyse, and share information about abortions, and report to Parliament each year on how the abortion law is operating (section 14).

Some of the Committee's other responsibilities include ensuring there are abortion facilities throughout New Zealand and issuing Standards of Care for women requesting an abortion.

Alongside the specific responsibilities of the Abortion Supervisory Committee, the Ministry of Health has general oversight responsibility for the health system within which abortion services are provided. As for other health services, the Ministry sets national service specifications, and the Service Coverage Schedule, as well as national monitoring and reporting requirements for District Health Boards (DHBs). However, these do not apply to private providers, unless they are providing services as a sub-contractor to a DHB.

#### *Informed consent*

The Code of Health and Disability Services Consumers' Rights imposes standards for rights of consumers and duties of providers. These apply to abortion services in the same way as other health services, including the right to be fully informed and consenting, give free and informed choice, and the right to effective communication (including the right to an interpreter).

Under the CSA Act, where a patient lacks the capacity to consent, a medical practitioner is required to consult another practitioner to assess the patient's condition and the likely effect of continuing with the pregnancy (section 34).

For a person with diminished mental capacity for whom an abortion may be being considered, the Protection of Personal and Property Rights 1988 provides a process for welfare guardians to make decisions on behalf of that person (Part 2). There is also additional protection provided by the courts for individuals who are not able to take care of themselves. This is through the principle of *parens patriae* (an obligation on the state to take care of those who are not able to take care of themselves, which allows the Court can make whatever orders it deems necessary to protect the vulnerable individual).

The Care of Children Act 2004 provides that minors' can consent to or refuse an abortion as if of full age (section 38).

## *Counselling*

The CSA Act requires women to be informed of their right to seek counselling after certifying consultants have decided whether to authorise an abortion (section 35). The Abortion Supervisory Committee's Standards of Care require abortion service providers to have professionals available with suitable training in counselling. The standards also state that counselling must be free and easily accessible.

## **Problem**

The current regulatory system for abortion is different from other health matters. For example, other health services (such as common surgical procedures for particular conditions) do not have specific legislative provisions for how a service is accessed, where a procedure may be performed, and by whom.

## **Criteria**

The criteria used to assess the proposed regulatory system against the status quo are set out below, developed from the health-focused objectives set out in section 2.3. They are weighted equally.

### **1) Timeliness**

- Enables those considering an abortion to access services without unnecessary delay

### **2) Equity**

- Promotes choice and fair access to appropriate health services (regardless of ethnicity, geography, financial situation, or other demographic factors)
- Removes stigma associated with abortion

### **3) Level of care**

- Provides quality, safety, and standards of care
- Allows for alignment with advancements in health care
- Encourages a sufficient workforce of health practitioners

### **4) Effective regulatory controls**

- Maintains a quality regulatory framework for the provision of abortion services
- Achieves compliance with the law through appropriate accountability mechanisms.

## **Options**

The proposals for the regulatory system could apply under any of models outlined in section 3.2.

### *Access to abortion services*

The Law Commission proposes removing the current restrictions in the CSA Act about access to services (referrals to certifying consultants, the licensing of facilities, and who can perform abortions), so that the general health regulatory framework applies without any additional legal controls. The Commission notes these restrictions appear to be significant contributing factors to access and availability issues.

### Self-referral

The Law Commission proposes that women could access abortion services directly or be referred by any health practitioner they choose to consult (for example, a general practitioner, nurse, midwife or counsellor). This reflects the way in which people engage with health services and that

many people's main point of contact with the health profession may not be a doctor. Self-referral could have a significant positive impact on the cost and accessibility of services.

#### Facilities regulated by health law

Removing the current licensing requirements could allow for early medical abortion to be available at a wider range of health care facilities (for example, sexual health services and medical centres). The safety of facilities for surgical abortion would be governed by general health law.

#### Health practitioners regulated by health law

Abortions could be performed or administered by a health practitioner with appropriate qualifications and experience, as determined by the scopes of practice issued by health profession regulatory bodies. The qualifications and experience required may differ depending on the method of abortion (i.e. medical or surgical).

#### *Oversight of abortion services*

The Law Commission proposes shifting the functions of the Abortion Supervisory Committee, which is currently supported by the Ministry of Justice, to the Ministry of Health (and disestablishing the Committee). This is because the Ministry of Health is responsible for the oversight of other health services and is best placed to ensure that abortion services are adequately funded and accessible.

The Ministry of Health could have responsibility for:

- collecting statistics on abortion and overseeing the distribution and funding of abortion services (including counselling services), and
- best practice guidelines/standards of care for abortion services, in consultation with abortion service providers and Māori.

### **Informed consent and counselling**

#### Status quo for informed consent and capacity requirements

The Law Commission said general health law could continue to govern how women (including people under the age of 16) give informed consent to abortion, and also govern the disclosure of health information about a person under 16. The statutory provision in the CSA Act should be repealed so that consent by people with limited mental capacity is governed by general health law and any relevant professional standards or guidelines.

#### Counselling

The Law Commission said a modified status quo could be considered that would involve a statutory requirement for abortion service providers to offer counselling, if specific abortion legislation is enacted (under Model B or Model C). The Law Commission said counselling should not be mandatory. Service standards and/or standards of care should require abortion service providers to have counselling available to women considering abortion or who have had an abortion, and set out the necessary qualifications and knowledge for counsellors.

## Assessment against criteria

The table below assesses the contribution each option makes to the criteria.

Regulatory option	Timeliness	Equity	Level of care	Effective
<p>Access:</p> <ul style="list-style-type: none"> <li>Self-referral</li> <li>Facilities regulated by health law</li> <li>Health practitioners regulated by health law</li> </ul>	<p>Most health practitioners and the Abortion Supervisory Committee said self-referral or referral by any health practitioner would significantly reduce delays.</p> <p>A specific provision would ensure that a woman may self-refer to an abortion service, overcoming any inconsistencies in the ability to self-refer across DHB areas.</p> <p>It is likely that over time the number of qualified practitioners able to perform early medical abortions will increase, due to a reduction in stigma and legislative barriers.</p>	<p>Reduces stigma as moving away from treating abortion as a criminal matter and treating as a health issue.</p> <p>Provides greater choice for women because more facilities and qualified practitioners may be available over time.</p> <p>Removal of legal barriers to access, would provide the benefits of less time and cost (including for travel) for a range of groups – notably rural women, women on lower incomes, women with dependents, employed women, Māori women.</p>	<p>Improvements in technology are more easily introduced.</p> <p>Early medical abortion integrated more completely into abortion services as an option for women.</p> <p>Health practitioners may become more routinely trained in abortion care, reducing workforce challenges and impacts on the availability of services.</p>	
<p>Oversight:</p> <ul style="list-style-type: none"> <li>Ministry of Health – data, funding, best practice guidelines</li> </ul>		<p>Ministry of Health may have greater impact than Abortion Supervisory Committee on service provision because of funding levers across system.</p> <p>Opportunity to improve on existing data quality, and provide information on equitable access to services.</p> <p>Ministry of Health can consider any necessary alignment with <i>He Korowai Oranga</i> New Zealand's Māori Health Strategy.</p>	<p>Standards of care maintained.</p>	<p>Health system framework continues to apply, including oversight and accountability mechanisms, complemented by new committee.</p>
<p>Counselling:</p> <ul style="list-style-type: none"> <li>Counselling should be available</li> </ul>			<p>Availability of counselling services is important, and having a legislative requirement that counselling be offered would ensure this was available.</p>	

## Conclusion

The regulatory framework meets the criteria identified, giving access to abortion services without unnecessary delay, promoting equity, removing stigma, maintaining or improving levels of care, and providing sufficient accountability mechanisms.

### 3.4 Criminal aspects of abortion, and other accountability mechanisms and safeguards

Under the Cabinet Manual the Ministry of Justice is responsible for reviewing all proposals to create new criminal offences or penalties or alter existing ones, to ensure that such provisions are consistent and appropriate.

#### Status quo

Accountability for unlawfully providing or procuring an abortion varies depending on the person involved.

#### *CSA Act and Crimes Act*

##### Pregnant people

The CSA Act makes it an offence for a woman to unlawfully procure or attempt to procure her own miscarriage, punishable by a fine of up to \$200 (section 44). As with the Crimes Act offences, “unlawfully” means a lack of belief that a ground in section 187A of the Crimes Act applies.

##### Health practitioners

Crimes Act offences apply to people other than the pregnant person who assist with or perform an abortion. They make it an offence for any person to:

- intentionally and unlawfully perform acts to procure miscarriage, punishable by 14 years’ imprisonment (section 183); and
- unlawfully supply or obtain any substance or instrument, believing it is intended to be used unlawfully to procure miscarriage, punishable by 7 years’ imprisonment (section 186).

These provisions apply regardless of whether the substance, instrument, or method could actually procure miscarriage (section 187). Section 183 applies whether or not the person was pregnant.

“Unlawfully” means the person performing the abortion does not believe one of the grounds for abortion set out in section 187A of the Crimes Act applies. If, however, the person procuring the abortion is a doctor acting under a CSA Act certificate, their conduct is presumed to be lawful unless the prosecution positively establishes that they did not believe any of the grounds applied (section 187A(4)).

The CSA Act also creates two strict liability offences that may apply to health practitioners (section 37). A person commits an offence if, except in cases of necessity, they perform an abortion:

- somewhere other than in a licensed institution, or
- without a certificate issued by two certifying consultants per section 33 of the CSA.

The prosecution does not need to show that the person knew they were not in a licensed institution or that no valid certificate had been issued. However, a person can avoid liability if they show they believed a certificate had been issued. The penalties are up to 6 months’ imprisonment or a fine of up to \$1,000.

##### Unqualified people

The Crimes Act and the CSA Act offences also apply to unqualified people in the same way as they

do for medical practitioners. There may be situations where unqualified people commit an offence under other provisions in the Crimes Act (for example, an abortion could be an assault).

#### *Accountability in the health legal framework*

##### Health practitioners

The Health Practitioners Competence Assurance Act 2003 (HPCA Act) provides for complaints and disciplinary processes against health practitioners. Health practitioners are registered under a scope of practice, overseen by a regulatory body, and subject to professional standards. The HPCA Act has accountability mechanisms if an abortion by a health practitioner was performed negligently, without consent, or not in accordance with any relevant standards.

The Code of Health and Disability Services Consumers' Rights also provides patients with the right to have services provided that comply with legal, professional, ethical and other relevant standards. Under the Code patients also can complain about a health service.

##### Unqualified people

The HPCA Act provides offences for unqualified people claiming to be a health practitioner (section 7) or for anyone who performs certain activities without the proper scope of practice (section 9). The Medicines Act 1981 provides offences for the unauthorised supply or administering of prescription medicine.

#### **Problem**

##### *Criminalisation of conduct raises stigma*

Medical procedures are not usually the subject of specific criminal offences. Significant stigma attaches to the criminalisation of conduct, which is why activities should not be criminalised unless the conduct is considered to be morally blameworthy. This stigma is likely to negatively impact on people who wish to obtain an abortion as well as those involved with procuring it, including health practitioners.

##### *Availability of services issues*

There is a very limited pool of practitioners involved in abortion services. This may in part be because practitioners are disinclined to provide abortion services which expose them to criminal liability. Continuing to criminalise this conduct may perpetuate the limited availability of abortion services.

##### *Duplication of offences*

Conduct that is already sanctioned should not be further criminalised unless required, for reasons including that duplication of offences provides options for prosecutors to decide which provisions to charge under. This can lead to disparate outcomes for identical conduct, depending on prosecutorial discretion.

Abortions by health practitioners can be sanctioned under the health legal framework, the Crimes Act and the CSA Act. Similar duplication issues arise for unqualified people who perform abortions unlawfully, as they can be subject to the CSA, the Crimes Act abortion offences, as well as potentially being criminalised under other parts of the Crimes Act.

#### **Objective**

The objective is to align any offence and accountability provisions that would underpin the proposed regulatory framework for abortion services with the broader health legal framework in New Zealand. The accountability mechanisms should fulfil the general principles for compliance and enforcement set out by the Legislation Design and Advisory Committee in its Legislation Guidelines.

## Criteria

The criteria used to assess the proposed enforcement mechanisms are set out below, developed in the context of a health approach. They are weighted equally.

### 1) Necessary for enforcement

- There is no existing sanction for the undesirable conduct, and duplication is avoided
- If no existing sanction, the proposed mechanism is necessary and proportionate to ensure that undesirable conduct is appropriately sanctioned

### 2) Consistency

- The mechanism is consistent with the purpose of the legislation, which is to provide abortion services
- The mechanism is consistent with the existing health legal accountability framework

## Options

The Law Commission proposes either repealing the criminal offences for abortion or amending them so that they only apply to unqualified people who perform abortions. The Commission considers that the safety of women is already protected by other existing offences in the Crimes Act and health legislation, as well as the disciplinary regime that applies to health practitioners. The Commission notes that if Model B or C is adopted, a regulatory offence under health legislation could be considered to ensure that people who perform abortions comply with the law.

### *For pregnant persons*

Repeal the offence for a pregnant person who procures their abortion.

### *For registered health practitioners*

Either:

- a. Option 1 (status quo): retain offences which specifically criminalise health practitioners for unlawfully providing abortions, or
- b. Option 2: Repeal all offences which specifically criminalise health practitioners' activities relating to abortion, and instead rely on the general health and criminal provisions which regulate other medical procedures and health services.

In addition, if Models B or C are preferred (introducing an amended statutory test), either:

- a. Option 1: Insert regulatory offence into the CSA Act (or replacement legislation) applying to any health practitioner who performs an abortion without believing the statutory test is met, or
- b. Option 2: Rely on the existing disciplinary regime in the Health Practitioners Competence Assurance Act. Practitioners who fail to apply the test would be subject to the same disciplinary regimes as would apply for other misconduct.

### *For unqualified persons*

Either:

- a. Option 1 (status quo): retain specific offences which criminalise the actions of unqualified persons providing abortions, or
- b. Option 2: Repeal all offences which criminalise activities specifically relating to abortions performed by unqualified persons, and rely on the general health and criminal provisions which regulate actions taken by unqualified people in relation to other medical procedures and health services.

## Assessment against criteria

The table below assesses each option against the criteria.

Offence option	Necessary for enforcement	Consistency
<p><i>Pregnant person:</i></p> <ul style="list-style-type: none"> <li>• No criminal offence</li> </ul>	-	Yes. No obligations are placed on the person seeking the health service.
<p><i>Health practitioners:</i></p> <ul style="list-style-type: none"> <li>• Retain criminal offence for unlawfully providing abortions</li> <li>• No criminal offence in relation to providing abortions</li> </ul> <p>Under Model B or C:</p> <ul style="list-style-type: none"> <li>• Regulatory offence for performing an abortion without believing the statutory test is met</li> <li>• No regulatory offence for the statutory test</li> </ul>	<p>No. Conduct is already subject to existing general criminal and health law sanctions. Specific criminal sanction is likely to continue to stigmatise.</p> <p>-</p> <p>No. Conduct is already subject to the existing disciplinary regime in the Health Practitioners Competence Assurance Act. Specific criminal sanction is likely to continue to stigmatise.</p> <p>-</p>	<p>No. A specific health procedure is not normally criminalised. Work force availability may be reduced, undermining the purpose of the legislation.</p> <p>Yes.</p> <p>No. A specific health procedure is not normally criminalised. Work force availability may be reduced, undermining the purpose of the legislation. This offence would create a new 'unlawful act' for purposes of Crimes Act, retaining the application of the Crimes Act to this conduct.</p> <p>Yes.</p>
<p><i>Unqualified persons:</i></p> <ul style="list-style-type: none"> <li>• Retain offence for providing abortions</li> <li>• Repeal all offences specifically relating to abortions</li> </ul>	<p>No. Conduct is already subject to existing general criminal and health law sanctions. Specific criminal sanction may continue to associate abortion with stigma.</p> <p>-</p>	<p>No. A specific health procedure is not normally criminalised.</p> <p>Yes.</p>

## **Conclusion**

The Ministry of Justice concludes that maintaining or introducing criminal offences is generally incompatible with a health approach. Health laws and general criminal provisions provide necessary and proportionate mechanisms to regulate abortion services and any unqualified people providing abortions (as with other medical procedures and health services). These provide sanctions against conduct that is unlawful, unsafe or undesirable. Additional offences would also duplicate existing sanctions and may maintain a level of stigma surrounding abortion.

The preferred option is for no offences specifically relating to abortions for pregnant people, health practitioners (including if there is a statutory test for the lawful grounds for abortion in Models B and C), or unqualified people.

## **3.5 Offence of killing an unborn child**

### **Status quo**

Section 182 of the Crimes Act provides for an offence of killing an unborn child. It makes a person liable to 14 years' imprisonment who causes the death of any fetus in such a manner that they would be guilty of murder if it had become a human. A person is not guilty of this offence if they were acting in good faith to preserve the mother's life.

### **Problem**

The offence was not enacted to apply to abortion and has been used only to prosecute people who have assaulted pregnant persons causing the death of the fetus. The Law Commission notes that the courts currently interpret this offence so it does not apply to the conduct regulated by the abortion offences.

### **Objective**

The Minister of Justice indicated in his request for advice from the Law Commission that no review of this offence was required. If the abortion offences are changed, it would be necessary to ensure the offence did not unintentionally apply to abortion services.

### **Options**

The Law Commission proposes that the offence could be amended to clarify that it does not apply to lawful abortion. Alternatively the Law Commission suggests repealing the offence and amending the Crimes Act so that assaults on pregnant women are prosecuted under other provisions. For example, by providing that grievous bodily harm includes causing the death of a fetus of a pregnant woman, but excludes lawful abortion.

### **Assessment**

Depending on the scope of any other proposed changes, it may be necessary to remove, or amend this offence to ensure it does not undermine the policy intent of other amendments.

Retention of the offence could specifically sanction the conduct of those who assault pregnant persons causing the death of a fetus and signal Parliament's condemnation of these actions. If retained, the Ministry agrees with the Law Commission that the offence would require amendment to ensure the offence of killing a fetus did not unintentionally apply to abortion services.

### **Conclusion**

The Ministry of Justice has no preferred option. Either amending the current section 182 offence, or amending other Crimes Act provisions, could capture the conduct of assaulting pregnant women with the intention of causing a miscarriage. The objective of not unintentionally applying the relevant offence to abortion services could be achieved under either approach.

## 3.6 Safe access zones

### Status quo

There are existing legal protections against intimidating behaviour around abortion facilities. Under the Summary Offences Act 1981, some forms of intimidating and anti-social behaviour are prohibited including: offensive behaviour or language (section 4(1)(a), (b), and (c)); intimidation (section 21(1)(d) and (e)); and obstructing a public way (and section 22). The Trespass Act 1980 also prohibits trespass after warning to leave (section 3).

### Problem

Submitters to the Law Commission's review noted that demonstrations and other protests outside abortion providers can be distressing for women accessing clinics and those providing the services.

There is limited evidence of the degree of harm protesters may have on medical practitioners or women accessing abortion services. This lack of evidence may be due to stigma around the subject of abortion. However, a recent study from Monash University found that protester activity outside abortion clinics led to anxiety, distress, stigmatisation, concerns about the privacy of patients and medical practitioners and individual safety, and was detrimental to both patients and staff wellbeing. The study determined that a few individual acts of protest would be reasonably likely to deter a health professional from performing, or assisting in the performance of a termination.<sup>xv</sup>

#### *What are safe access zones?*

Safe access zones are areas within a specified radius of an abortion clinic. In jurisdictions where these have been created, the law makes certain behaviour within the zone an offence (such as harassing, intimidating and protesting).

### Law Commission's conclusions

The Law Commission did not see clear evidence to justify the introduction of safe access zones in New Zealand. It said that existing laws around intimidating and anti-social behaviour appeared to be adequate.

Most health professional bodies and abortion providers who were asked about safe access zones by the Commission felt that safe access zones are not needed. Some submitters to the Law Commission were concerned that safe access zones could serve to emphasise demarcation around abortion clinics and encourage demonstrations at the zone boundaries.

### Options

The Ministry of Justice has considered three options:

- retain the status quo - no specific legislative provision for safe access zones, with existing provisions under the Summary Offences Act 1981 and the Trespass Act 1980 being relied upon for some behaviour
- safe access zones around all abortion service providers
- a regulation-making power to introduce safe access zones around specific abortion providers, on application to a Minister.

### New Zealand Bill of Rights Act analysis

Safe access zones would engage NZBORA rights such as peaceful assembly, freedom of association and freedom of expression. There are competing considerations under NZBORA and the right to access health services safely. To justify limits on freedoms, a sufficiently important objective must be identified, the limit on rights must be rationally connected to the objective, the

limit must impair the rights only so far as is reasonably necessary to achieve the objective, and the limit must be proportionate to the objective.

The objective of safe access zones is to ensure the protection of a women's right to access health services safely and free from harassment, which is a sufficiently important objective. Safe access zones may support equity of access to abortion services and may serve to reduce stigma experienced by women and medical practitioners – supporting the provision of safe clinical care.

We consider that the protection of a women's right to access health services safely and free from harassment is a sufficiently important objective.

A regulation-making power to introduce safe access zones may be rationally connected to the objective, and proportionate. A safe access zone could be implemented in cases on the condition of demonstrable harm to women or medical practitioners accessing a specific clinic.

A regulation-making power would provide the executive power to restrict NZBORA rights through a legislative instrument. If a regulation-making power was incorporated into any legislative change, care would need to be taken to ensure adequate safeguards are included to ensure that the restrictions on NZBORA rights go no further than is necessary to achieve the objective in a proportionate manner. If so, the restrictions are more likely to be justified.

The limit on rights in introducing safe access zones around all abortion providers may not be rationally connected to this objective, nor proportionate. The Law Commission did not identify strong evidence to warrant a large-scale limitation on these rights. There is a risk that blanket safe zones would limit rights further than required to achieve the objective, particularly given the importance of these civil rights in a democratic society.

### **Conclusion**

The Ministry of Justice does not have a preferred position regarding whether safe access zones should be implemented. If safe access zones are contemplated, the Ministry prefers the option for a regulation-making power, rather than the safe access zones around all providers, due to the NZBORA implications.

## **Section 4: Conclusions**

### **4.1 What option, or combination of options, is likely best to address the problem, meet the policy objectives and deliver the highest net benefits?**

Conscience issues arising from the proposed changes to the policy settings in the legislation (which the Ministry of Justice has assumed to be the lawful grounds for abortion and conscientious objection) raise legal considerations of consistency with the New Zealand Bill of Rights Act 1990, and any justified limitations on rights and freedoms enshrined in that Act. New Zealand also has a range of international human rights obligations that are relevant.

Public submissions to the Law Commission expressed a wide range of views on these issues reflecting various ethical and value-based judgments.

The regulatory framework for abortion law proposed by the Law Commission, which would underpin any of the Models proposed for the lawful grounds for abortion, would enable women's health needs to be fully incorporated into the New Zealand public health system.

The evidence gathered by the Law Commission from the health sector on the impact of aligning with the existing health legal framework appears sound. There is a lack of in-depth evidence from women about the impact of the current system. This has required some assumptions to be made

about the impact of the proposed changes for pregnant people who consider having an abortion.

The Ministry of Justice's preferred option is for no specific offences relating to procuring or performing an abortion. Maintaining or introducing criminal offences is generally incompatible with a health approach, and health legislation provides for compliance with the law.

The Law Commission did not see clear evidence to justify the introduction of safe access zones and says existing laws around intimidating and anti-social behaviour appeared to be adequate. The proposed regulation-making power to provide safe access zones for women could allow the NZBORA implications of these zones to be better considered.

## **4.2 Summary of costs and benefits of the proposed regulation of abortion services in section 3.4**

The costs and benefit analysis of this section applies only to the proposed regulatory framework for access and oversight of abortion services set out in section 3.4 above. There is no analysis of the options for the likely conscience matters, and these will be raised and tested as a part of any Parliamentary select committee process.

Under the proposed regulatory framework the Ministry of Health would assume full responsibility for general oversight of abortion services as a part of New Zealand's public health system. The Ministry of Health has considered the costs and benefits of the framework and has provided the information in this section.

The Ministry of Health expects that overall the monetised costs and benefits of the proposed regulatory approach would be fiscally neutral for the government.

### **Expected one-off set up costs**

#### *Ministry of Health*

The Ministry of Health expects that it will have costs of approximately \$5.0-6.0m (medium-high certainty) in the transition phase from the current system to the proposed approach, from its work on:

- ensuring that information is nationally available to the public on how to access services and to support informed consent processes and discussions
- working with professional bodies and colleges to develop and disseminate information to practitioners re: revised legal requirements, and best practice standards
- workforce development planning, development of standards and clinical guidance
- updating any requirements as part of the national service planning framework, including service coverage requirements, national service specifications, or coding
- making any necessary contractual changes for nationally funded services (for example, sexual health clinic) to reflect the new legal framework
- undertaking policy work to develop national standards and guidance and ensuring the integration of abortion services with other related programmes of work (for example, screening for family violence and coercion)
- reviewing regulatory rules that impact on abortion services and ensuring that operational aspects are clear under the proposed system (for example, the use of abortion medication under the Medicines Act, and the scopes of practice that cover abortion services)
- developing a system for collecting, analysing and publishing annual abortion data (through regulations, if needed)

- establishing and managing a project work stream for transition and implementation.

#### *District Health Boards*

The Ministry of Health expects that the implementation of self-referral systems would have transition costs for DHBs, but these are not expected to be substantial. While DHBs have referral systems in place the processes and systems required for self-referral are likely to be different and would require additional training for staff. For DHBs the set up of data collection and analysis would be approximately \$1.0m.

#### *Regulatory authorities and professional training bodies*

Regulatory authorities and professional training bodies would have an initial cost in updating professional standards, guidance and training, and working with the Ministry of Health to clarify operational aspects are clear under the proposed system, such as scopes of practice.

### **Expected ongoing costs**

#### *Ministry of Health*

The Ministry of Health expects that it will have ongoing annual costs of approximately \$5m (medium-high certainty) from:

- oversight and monitoring abortion services
- a system for data collection, analysis and reporting
- workforce development in response to any longer-term changes (for example, widening pool of medical practitioners making referrals)
- supporting and providing information to consumers.

#### *District Health Boards*

The Ministry of Health expects that ongoing annual costs for DHBs of approximately \$1.0m would arise from data collection and reporting to the Ministry of Health. There would be negligible costs in maintaining the requisite referral system and in contract management of abortion services.

#### *Regulatory authorities and professional training bodies*

Regulatory authorities and professional training bodies would have ongoing costs through maintaining professional standards, guidance and training. In the longer-term, if the relevant regulatory authority wanted to expand one or more scopes of practice to include abortion services, that consultation process would attract some costs.

#### *Health practitioners*

The Ministry of Health identifies that there could be a small cost for conscientious objectors if they are required to make a referral.

### **Monetised benefits**

#### *Women seeking abortion services*

The Ministry of Health notes that the proposal for self-referral would require women to move through fewer process stages than the current system of referral by a doctor and approval by two certifying consultants.

The Ministry of Health considers that self-referral may reduce the cost for women seeking abortion services. These women would no longer be required to pay to see a general practitioner when seeking a referral. However, it is difficult to anticipate the different circumstances facing individual women, and some women may still seek confirmation of a pregnancy from their primary health provider.

In particular some costs to women may be reduced or eliminated. Currently women who initially seek referral may be advised of a conscientious objection, and then they are required to seek referral elsewhere. Self-referral would reduce the cost and time impact as women could seek services directly. Costs may also be reduced for women in areas with few services, who currently need to travel, take leave from work or arrange childcare to seek a referral.

#### *Wider government costs*

The costs of certifying consultants and administering the licensing regime currently funded through the Ministry of Justice will be eliminated.

The Ministry of Health anticipates that earlier access to services through self-referral means that a greater number of women would have the option of an early medical abortion. Generally early medical abortions are performed in the early stages of pregnancy.

The Ministry of Health considers that, over time, New Zealand's current proportion of early medical abortions may increase if more women have the option to more readily choose early medical abortion. The provision of surgical abortion services generally have a greater cost to the health system than early medical abortions. An increased rate of early medical abortion may have the benefit of further reducing the already low rate of complications from having an abortion.

#### *Abortion service providers*

Health facilities would no longer have to dedicate administrative resources to licensing applications to the Abortion Supervisory Committee. This would be negligible as the existing processes and procedures relating to health facilities would continue to apply.

### **Non-monetised benefits**

#### *Women seeking abortion services*

The Ministry of Health notes that there is a combination of aspects of the proposals in section 3.4 that it would expect to reduce stress for women seeking abortion services. For example, increased timeliness in the process could help reduce uncertainty for women, and help ensure there is access to a range of appropriate services and support at the earliest opportunity. Having the option of an early medical abortion is beneficial because these procedures are generally less stressful and invasive for women than surgical abortion.

#### *Abortion service providers*

The Abortion Supervisory Committee's *Standards of Care for women requesting abortion in Aotearoa New Zealand* (2018) state that early medical abortions are also generally less stressful for the health practitioners involved.

### **4.3 What other impacts is this approach to the regulation of abortion services described in section 3.4 likely to have?**

The Ministry of Health has identified other impacts of the proposed regulatory approach for access and oversight of abortion services set out in section 3.4.

#### *Health sector workforce*

The Ministry of Health notes that the disestablishment of the statutory role of certifying consultants will result in a subsequent loss of income for those practitioners. As well as approving the grounds for an abortion, certifying consultants may also perform abortions. When the role of approving abortions is removed there is a risk that some of these experienced health practitioners will withdraw from providing abortion services.

As with any change to a legal framework, there may be some uncertainty from health practitioners

about the new aspects of the system. For example, application of the statutory test for abortions for pregnancies of more than 20 weeks' gestation.

There may be concerns from the health sector around changes to conscientious objection. The Health Practitioners Competence Assurance Act 2003 imposes a duty on practitioners who have a conscientious objection to abortion to disclose their objection to the pregnant person and inform them they can obtain the abortion services elsewhere. The proposed change is for an obligation for conscientiously objecting health practitioners to refer the pregnant person to another practitioner who can provide the referral. This change to conscientious objection would apply to all reproductive health services.

The Ministry of Health expects that a small group of health practitioners will continue to be conscientious objectors to abortion at any gestational stage, and a larger group may be conscientious objectors for later gestation abortions particularly over 20 weeks. Some submitters to the Law Commission, including the New Zealand Medical Association and Nurse Practitioners New Zealand, supported the retention of the existing provisions for conscientious objection.

These impacts and concerns may be alleviated by communicating with practitioners about how the services will be provided under the existing health system. Concerns should reduce as the regime becomes more established.

The Ministry of Health has also identified the need to consult with professional groups to ensure clarity of and potentially expand scopes of practice, training for professions if their scopes of practice are expanded, and training of health practitioners to discuss abortion and make referrals.

#### *Health system*

Currently surgical abortions can involve the provision of subsidised long-acting reversible contraception as a part of the same procedure. If there is a higher proportion of early medical abortions, there will need to be consideration of how the provision of this contraception remains available.

#### *Women*

Some pregnant women seeking an abortion may find the change to the process confusing. Clear information to the public about the changes would help mitigate any confusion.

If a safe access zone was introduced for a specific facility, the harm attributed to the women accessing the facility would be reduced.

#### *Ministry of Health*

If safe access zones are introduced, processes to support the establishment of these zones would likely attract a cost.

The Ministry of Health has also identified that there are potential costs of legal challenges to the proposed system, including application of the statutory test under Model C.

The Ministry of Health notes that data collection and analysis under the proposed system provides an opportunity to assist in understanding equity impacts of access to abortion services.

#### **4.4 Is the proposed regulation of abortion services described in section 3.4 compatible with the Government's 'Expectations for the design of regulatory systems'?**

The Ministry of Health advises that the proposed changes are compatible with the Government's 'Expectations for the design of regulatory systems'.

There are clear objectives that the changes seek to achieve. The proposed reforms are expected to be cost neutral. The purpose of the law reform is to bring abortion services under the same regulatory framework as other health services, generally removing areas of inconsistency in the

law. The proposed changes support compliance with New Zealand's international obligations, including the recommendations by the United Nations Convention on the Elimination of Discrimination Against Women Committee has made to New Zealand.

## Section 5: Implementation and operation

### 5.1 How will the new arrangements for the regulation of abortion services described in section 3.4 work in practice?

As the Ministry of Health would be responsible for implementing the proposed changes to services it has provided the analysis in this section.

The Ministry of Health notes that the proposals would require legislative change to the Crimes Act 1961, the Contraception, Sterilisation, and Abortion Act 1977, and the Health Practitioners Competence Assurance Act 2003. They may also require minor consequential amendments to other health legislation, to ensure that abortion services are regulated by the existing health regulatory system, including the Medicines Act 1981, the New Zealand Health and Disability Act 2000, and the Health and Disability Commissioner Act 1994.

Legislative change would result in immediate decriminalisation and immediate changes to the abortion referral process (certifying consultants would no longer be part of the referral process).

However, immediate implementation would not be required for all of the proposed changes. For example, a delay in establishing self-referral pathways in some DHBs would not prevent women accessing referrals through their doctor or sexual health clinic as they currently do.

Administrative changes to self-referral processes may be further developed and refined after law reforms have come into effect. Regulation changes to allow for self-referral may have to be implemented in some DHBs.

If safe access zones are introduced, processes to support the establishment of these zones can be put in place when required.

The Ministry of Health recognises the need to implement data collection systems for abortion data, to maintain the quality of information currently being collected by certifying consultants and analysed by Statistics NZ and the Abortion Supervisory Committee.

The Ministry of Health anticipates that the proposed changes would likely take 1-2 years to implement in full.

#### *Implementation and operational aspects*

Specific operational and administrative changes overseen by the Ministry of Health will involve:

- ensuring that information is nationally available to the public on how to access services and to support informed consent processes and discussions
- working with professional bodies and colleges to develop and disseminate information to practitioners re: revised legal requirements, and best practice standards
- updating any requirements as part of the national service planning framework, including service coverage requirements, national service specifications, or coding
- making any necessary contractual changes for nationally funded services (for example,

sexual health clinic) to reflect the new legal framework

- undertaking policy work to develop national standards and guidance and ensuring the integration of abortion services with other related programmes of work (for example, screening for family violence and coercion)
- Developing a system for collecting, analysing and publishing annual abortion data (through regulations, if needed).

Some implementation work will also be required by other bodies:

- Registering authorities will review their scopes of practice and guidance documents to ensure that abortion services are clearly covered as appropriate.
- DHBs will review service planning to ensure timely access to abortion services, including counselling services. They will also ensure planning for workforce needs and data collection processes is undertaken.

#### *Ongoing operation and enforcement*

The Ministry of Health would assume full responsibility for oversight of the abortion regime. Provision of abortion services would continue to be the responsibility of DHBs and aligned with the provision of other health services.

Enforcement would primarily be through the Ministry of Health, in partnership with DHBs. Professional regulatory bodies and the Health Practitioner Disciplinary Tribunal will continue to have an enforcement role in the conduct of individual practitioners. The Health and Disability Commissioner and the Director of Proceedings would continue to have a role in the resolution of health consumer complaints and the accountability of health service providers.

#### *Government's Expectations for regulatory stewardship*

No concerns have been identified with the Ministry of Health's ability to implement the framework in a manner consistent with the 'Expectations for regulatory stewardship by government agencies'.

## **5.2 What are the implementation risks of the proposed regulation of abortion services described in section 3.4?**

The Ministry of Health considers that ensuring that the requirements and processes for data collection and reporting are operational within the health framework may be a lengthy process, creating data gaps in the early phase.

Transitional arrangements will be required to maintain the quality and capacity of abortion services during the implementation phase of the proposed changes.

The Ministry of Health will develop a detailed implementation plan to ensure that these risks are adequately mitigated.

## Section 6: Monitoring, evaluation and review

### 6.1 How will the impact of the new arrangements for regulation of abortion services described in section 3.4 be monitored?

As the Ministry of Health would be responsible for monitoring the proposed changes to services it has provided the analysis in this section.

The Ministry of Health and DHBs have existing annual reporting and accountability obligations for services provided and service levels (including under section 38 of the New Zealand Public Health and Disability Act 2000, New Zealand Public Health and Disability (Planning) Regulations 2011, Part 4 of the Crown Entities Act 2004, and the Public Finance Act 1989).

These obligations give an overarching view of the services that DHBs provide. DHBs are only obliged to provide specific detail on a small range of health services, which often reflect government priorities. Reporting on abortion services is high level and does not capture the data currently collected by the Abortion Supervisory Committee. For example, the Committee collects data on the ethnicity of women receiving abortion services, which is not routinely reported by DHBs.

If the same level of detail is required to be maintained, the reporting arrangements between DHBs and the Ministry of Health would have to be adjusted to include more detail regarding the provision of abortion services.

Although there is an existing system for collecting and reporting good quality data through the Abortion Supervisory Committee, DHBs do not currently collect detailed information on abortion other than to monitor expenditure. The new data collection process to be established by the Ministry of Health provides an opportunity to improve upon existing data quality.

The priority is that sufficient data is available to monitor the impact of the changes on abortion services in New Zealand. This would include any change in overall abortion rates or trends, or changes specific to certain groups (for example, for Māori, or women in a particular age range).

The Ministry of Health's data collection process, coupled with existing DHB and Ministry of Health reporting, will provide information on how the changes have impacted on equitable and timely access to abortion services in New Zealand.

### 6.2 When and how will the new arrangements for the regulation of abortion services described in section 3.4 be reviewed?

The Ministry of Health expects to review the effect of the law change and the functioning of the regulatory regime annually for the first three years, and periodically after that. Monitoring will be ongoing as part of the Ministry's oversight of the health system.

<sup>i</sup> Statistics New Zealand, *Abortion Statistics: Year ended December 2017* (19 June 2018), [www.stats.govt.nz](http://www.stats.govt.nz), Table 1.

<sup>ii</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, paragraph 2.11, page 33.

<sup>iii</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, paragraph 2.12, page 33.

<sup>iv</sup> *Ladies in waiting: the timeliness of first trimester services in New Zealand* (2010) 7 *Reproductive Health* 1 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2918568/> (accessed on 28 September 2018).

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<sup>v</sup> *Factors affecting delays in first trimester pregnancy termination services in New Zealand* (2011) 35 *Australian and New Zealand Journal of Public Health* 140, <https://doi.org/10.1111/j.1753-6405.2010.00659.x> (accessed on 28 September 2018).

<sup>vi</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, paragraph 2.10, page 33.

<sup>vii</sup> Legislation Design and Advisory Committee, *Legislation Guidelines: 2018 Edition*, Chapter 24, page 111.

<sup>viii</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, paragraph 6.51, page 111.

<sup>ix</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, paragraphs 7.6-7.10, pages 122-123.

<sup>x</sup> *Geographical access to termination of pregnancy services in New Zealand* (2008) 32 *Australian and New Zealand Journal of Public Health* 519, <https://doi.org/10.1111/j.1753-6405.2008.00302.x> (accessed on 25 September 2018).

<sup>xi</sup> Abortion Supervisory Committee, *Report of the Abortion Supervisory Committee 2018*, Table 9.1, page 22.

<sup>xii</sup> Abortion Supervisory Committee, *Report of a Standards Committee: Standards of Care for Women requesting abortion in Aotearoa New Zealand* (January 2018), Standard 6.4, page 18.

<sup>xiii</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, Introduction, paragraph 7, page 8.

<sup>xiv</sup> Law Commission, *Alternative approaches to abortion law – Ministerial briefing paper*, Appendix 5 – Summary of Submissions, paragraph 12, page 209.

<sup>xv</sup> Monash University, *Submission to the Queensland Parliament Health, Communities, Disability Services and Domestic Family Violence Prevention Committee - Inquiry concerning the Termination of Pregnancy Bill 2018*, pages 4-10, [https://www.monash.edu/\\_\\_data/assets/pdf\\_file/0007/1470490/QLD-Gov-Termination-Bill-Sub.pdf](https://www.monash.edu/__data/assets/pdf_file/0007/1470490/QLD-Gov-Termination-Bill-Sub.pdf) [accessed on 3 July 2019].