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EDITORIAL

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Abortion law reform – what it means for primary care

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New Zealand (NZ) is actively involved in an abortion law reform debate. Regardless of our personal perspectives on abortion there is no denying that abortion in NZ is common with 13,285 abortions performed in the year ending 2017.[1] However, abortion is not currently treated as a health procedure, and for it to be a legal procedure in this country requires a woman or pregnant person to pass the statutory test outlined in the *NZ Crimes Act* (1961).[2] Under this Act two certifying consultants must agree that the person requesting an abortion meets specified criteria in order for an abortion to be granted.[2] The decision to have an abortion does not rest with the woman or pregnant person, but with two doctors who have been approved by the Abortion Supervisory Committee (ASC) to undertake this activity.[2]

In 2017, the ASC stated that the current NZ abortion law is outdated and out of step with modern health care provision.[3] In October 2018, in response to a directive from the Minister of Justice, and following extensive public consultation, the NZ Law Commission released a ministerial briefing paper with recommendations for how abortion could be managed as a health issue.[4] It proposed three models; Option A removed the requirement for a statutory test and the decision would be made by the pregnant person in consultation with a health practitioner. Option B required the pregnant person to meet a statutory requirement for abortion. Option C included a statutory requirement for pregnancies over 22 weeks gestation.[4]

On 8 August 2019, the first reading of the Abortion Legislation Bill was heard in The House and passed with a margin of 94–23 votes.[5] This Bill is a conservative version of Model C, specifying a statutory requirement for pregnancies over 20 weeks. It includes the ability for women and pregnant people to self-refer for an abortion, has no specific licensing required for health facilities providing abortion, and allows for abortion care to be provided by a range of health practitioners.[5] Under the proposed law, abortion would be treated as a health issue.

Currently an abortion can only be approved by facilities that have been granted a licence to do so by the ASC.[2] There are currently 27 such licenced institutions located mainly in urban centres. This creates inequity of access to abortion services and some pregnant people are required to travel considerable distances, often at their own cost and inconvenience, to get their abortion.[4] Restricted and inequitable access to abortion care creates barriers to the timing and type of abortion care a pregnant person chooses.[6] In a recent study of abortion methods and gestational age in high income countries NZ was found to have the lowest rate of abortions performed under nine weeks gestation.[6] In Sweden, 93% of abortions are medical, and 84% of all abortions are performed before nine weeks.[6]

The proposed legislative changes are in line with World Health Organization (WHO) recommendations that abortion should be affordable, accessible and situated in primary care, with referral pathways for higher level care as required.[7] They are also consistent with WHO recommendations that first trimester abortion, post abortion care, and post abortion contraception can be safely provided by mid-level providers; nurses, midwives, and non-specialist doctors wherever abortion is provided (ie high income and high resources settings or low income and low resource settings).[8] Expanding provision of abortion care to mid-level providers addresses shortages of specialist healthcare providers, reduces inequity of access to abortion care and increases the acceptability of the care as deemed by the service consumer.[8]

We need to be mindful that considering abortion as a health issue and bringing it out from under the criminal justice system, does not necessarily translate into better care. Canada decriminalised

abortion in 1988 and was at that time unique in its approach to considering abortion as a health issue rather than a legal issue. However, it took until 2017 for mifepristone, a drug used in medical abortion, to be available allowing greater access to abortion in primary care.[9] Prior to 2017, abortions were carried out surgically by family doctors or specialist gynaecologists located in hospitals or urban family planning clinics, significantly limiting access to people living in rural and remote areas.[10] However, inequity of access still exists due to barriers relating to geography, cost and knowledge. Research and advocacy work in this area is ongoing to address continuing inequities in sexual and reproductive health and rights in Canada.[9]

Looking to the imminent future in NZ, health providers in primary care will have an important role to play in planning for future abortion provision. We need to be proactive in developing a model for abortion care in our unique NZ context and provide training and support for the primary care workforce. This is our opportunity to create an evidence based, best practice abortion care model that facilitates high quality and acceptable care for the people of NZ.

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