The Complexity of Compiling Abortion Statistics

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SINCE LEGAL INDUCED ABORTION emerged as a medical procedure, States have rapidly passed laws liberalizing abortion—the number of legal abortions has increased more than twentyfold in 5 years *(1)*. In the United States today, approximately one legal abortion is reported for every five live births *(1)*.

As an adjunct to new State legislation on abortion, compilation of abortion statistics by the central health agency of the State is usually required. The Center for Disease Control (CDC), in its study of the epidemiology of legal induced abortion in the United States since 1969, has been communicating with State and local health agencies during their planning, initiating, and refining of abortion reporting systems according to each one's State laws and health regulations. This communication has brought about a broad understanding of the difficulties encountered in compiling statewide abortion statistics.

Legal Status

The legal status of abortion is the first major issue for consideration. No other kind of information collected in the arena of health statistics is more entangled than abortion in the legislative and judicial process.

Until 1967, when Colorado enacted its reform abortion law, all State laws were essentially the same, permitting abortion only to save the life of the pregnant woman. From 1967 to 1972, more than a dozen States passed laws that liberalized the circumstances under which abortions were permissible. For the most part, these laws followed the American Law Institute (ALI) Model Abortion Law, which recommended that abortions be legally permitted for the following reasons: *(a)* if the continuance of a pregnancy might cause physical or mental impairment of the woman, *(b)* if the child might be deformed, or *(c)* if the pregnancy was the result of rape or incest. Some States, however, passed laws with no legal restriction on reasons for which an abortion could be obtained before viability of the fetus.

Reform abortion laws often explicitly stated other conditions which had to be met before an abortion was performed, such as residency requirements or restrictions on the type of health facility used. These conditions and restrictions led to numerous court challenges of various State laws which culminated in the January 1973 Supreme Court decision concerning the Texas and Georgia (ALI) laws *(2)*. That ruling by the Supreme Court invalidated most of the conditions and restrictions written into the abortion laws of States that had reformed legislation. Furthermore, the Court's ruling also invalidated most State abortion laws, whether old or reform, on the grounds that the permissible reasons for abortion—life, health, deformity, rape, and incest—were too restrictive. Although reporting of all abortions was required by Georgia's ALI-type law, reporting was not argued as a constitutional issue before the Supreme Court and therefore was not responded to in the Court's decision.

The 1973 Supreme Court Decision precipitated a new round of legislative and court actions. These actions ranged from State laws passed in the spirit of the Supreme Court's intent to laws passed in direct defiance of the Supreme Court decision *(3)*.

While the pre-1967 restrictive abortion laws were similar from State to State, an appraisal of the current situation indicates that legislative and judicial activities since 1967 have resulted in much dissimilarity of laws. As a consequence of the shifting and unstable legal status of abortion in the United States, State health agencies, in general, continue to have difficulty in defining their roles and responsibilities for compiling statistics on abortion.

Reporting Authority

In States in which an abortion reporting system has been implemented, authority for reporting has come in one of the four following ways:

Establishment of reporting authority as part of reform abortion legislation. Reforming abortion legislation usually means modifying or rewriting that portion of the criminal code of the State that deals with circumstances under which performance of abortion is lawful. Authority to collect and compile statistics on abortion is usually given to State health agencies in a general manner so that both the data items and the modus operandi must be determined by the health officials. Some State laws, however, in giving authority also prescribe explicitly who should report, what should be reported, and how it should be reported. The amount of input that the central health agency had in drafting reform legislation usually determines whether the more explicit wording of the authority is more or less desirable than a general authority.

Reporting authority based on State vital statistics statutes. All States have vital statistics laws that require reporting of vital events, including fetal deaths. However, no uniformity exists regarding which fetal deaths are to be

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reported. Ten States require reporting of *all* fetal deaths, which means any pregnancy termination before delivery of a live-born infant, while the remaining States set gestational age criteria on reporting, which usually excludes reporting of fetal deaths of less than 20 weeks' gestation.

Most States that require reporting of all fetal deaths use their vital statistics authority to include reporting of legal induced abortions. However, a major problem with use of the vital statistics statute as a basis for obtaining abortion data is certification. Laws governing vital statistics, for the most part, require that legal certification of an event be filed permanently with the central health agency. Cooperation and compliance with reporting provisions of the law have usually proved more difficult to gain in data collection systems requiring a certificate as opposed to a non-certified statistical reporting form. Furthermore, the recommended standard fetal death certificate was developed before the advent of legal induced abortion and does not lend itself to the collection of pertinent statistics on induced abortion. Some States have dealt with both issues by modifying their vital statistics statutes to maximize authority and optimize reporting.

Reporting authority given by health regulations. In some States the health agency gathers abortion information under an existing or newly established regulation. Authority by regulation usually occurs only in States that have neither of the two legislative authorizations mentioned previously. Two problems have been observed in States that rely on the regulatory power of the health agency for obtaining abortion statistics. First, the health agency is often reluctant to put teeth into a regulation to collect abortion data when the legality of abortion is not legislatively clear. Second, the coverage of reporting under regulations may not be broad enough to include the free-standing abortion clinics, which are established outside the usual health care delivery system, and abortions performed in the physicians' offices.

Voluntary reporting. The States that have an operative voluntary reporting system usually have key persons in the central health agency who invest much time in soliciting the cooperation of various medical groups throughout the State. Certainly the voluntary reporting approach—albeit better than none—is fraught with difficulties, and the health agency usually seeks legislative or regulatory authority for reporting as soon as it is feasible.

What is an Abortion?

The question, "What is an abortion?" leads to another complex area that necessitates rethinking of old and established definitions. A fundamental issue is whether abortion should be thought of in terms of the fetus or the pregnant woman. Vital statistics laws relate to the fetus as a product of conception. Abortion laws relate, for the most part, to the performance of a medical procedure on a pregnant woman. The health community is faced with the responsibilities that logically relate to both the fetus and the pregnant woman. The point of conflict is seen when a physician performs a legal medical procedure during the first trimester of pregnancy and then is required to report that procedure by certifying a fetal death. There appears to be a growing consensus that abortion performed before viability should be viewed as a medical procedure and that the responsibility of the health agency is to the woman; therefore, reporting a procedure rather than a fetal death is more appropriate.

Another issue related to the question of what constitutes an abortion concerns the procedure called "menstrual extraction." Since the risk of morbidity and mortality associated with abortion increases with duration of pregnancy, there is a continuing effort to perform abortions as early in gestation as possible. Menstrual extractions are performed before pregnancy can be confirmed by means of standard pregnancy tests. Thus, only after the menstrual extraction has been done and the contents of the uterus examined pathologically can pregnancy be verified. Technically, menstrual extraction cannot produce an abortion in the absence of a pregnancy; therefore, it is not correct to definitionally equate an abortion with the performance of an abortion procedure. Consequently, just as the health statisticians have always had to be aware of definitional problems, they must be alert to definitional problems that arise in relation to abortion statistics.

Use of Abortion Data

Finally, a word regarding abortion data after they have been collected by the central health agency. Most States have made little effort to fully use abortion statistics. Abortions can be used as an indicator of unwanted pregnancies; thus, family planning personnel could use abortion statistics in planning and directing their programs to those population groups which have the highest rate of abortions. Since abortions are directly related to fertility, abortion statistics could be incorporated into analyses of general fertility trends and population growth estimates. Maternal morbidity and mortality associated with childbearing should be influenced by the practice of abortion as should perinatal and infant mortality.

Also, perhaps because of the sensitive nature of abortion, States often do not publish a periodic statistical report on abortion or include abortion statistics in other established statistical reports. It is hoped that there will soon be more widespread dissemination and use of abortion data in each State.

References

1. Center for Disease Control: Abortion surveillance; 1973. Atlanta, Ga., May 1975.
2. *Roe* v. *Wade,* 410 U.S. 113 (1973); and *Doe* v. *Bolton,* 410 U.S. 179 (1973).
3. Seven States adopt new abortion laws following Supreme Court decision. Fam Plan Pop Rep 2:47, June 1973.