Ensuring access to abortion in an era of cutbacks

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Résumé

AU MOMENT OÙ LE SYSTÈME DE SOINS DE SANTÉ s'adapte à des contraintes financières de plus en plus lourdes, les services d'avortement seront particulièrement vulnérables aux réductions. Le moment est donc venu de chercher des moyens de fournir des services d'avortement qui assureront leur disponibilité continue. Les progrès de la chirurgie et de l'anesthésie et la mise au point des avortements médicaux peuvent permettre d'offrir des services d'avortement dans des cliniques privées, des centres de santé communautaires et des cabinets privés de médecins. Il faut aussi envisager de transférer des gynécologues aux omnipraticiens la responsabilité première des services d'avortement et offrir des incitations et une rémunération appropriées pour la prestation de ces services dans un éventail de contextes non hospitaliers.

Access to abortion services is an indicator of a society's attitude toward women and their right to reproductive choice. It is now nearly 30 years since provisions to the Criminal Code set guidelines under which therapeutic abortions could be performed in Canada, and almost 10 years since this law was struck down as unconstitutional in the Morgentaler decision.[1,2] Abortions no longer required the approval of hospital therapeutic abortion committees. They were no longer regulated under the Criminal Code or subject to provincial laws and regulations. The way was opened for provinces to license and fund free-standing abortion clinics.

Nevertheless, access to abortion services continues to be inequitable across the country, varying from province to province and region to region. Nor has abortion ever been considered equivalent to other surgical procedures. Like euthanasia, it has been singled out and debated with great intensity and emotion. Despite the fact that no law in Canada currently limits the provision of abortion services in publicly funded hospitals, abortion remains a discretionary procedure subject to local hospital policy and the availability of physicians. At the same time, for many personal and sociologic reasons women are reluctant to consider the termination of an unwanted pregnancy as a routine procedure equivalent to any other surgical intervention. In this regard, they and their partners and families are influenced by their own beliefs and values as well as by those of their physicians and the wider community. Even those who argue most vigorously for the right of women to reproductive choice consider abortion to be different from all other medical services.

According to Statistics Canada, abortion procedures are the most frequently performed surgical procedures in Canada.[3,4] In the mid-1970s the Department of Justice appointed the Badgley Committee to study the abortion law in practice. The committee concluded that the law was not being applied equitably across Canada and that public attitudes led to these inequities.[5] Nothing has changed in the intervening years. Other surveys and studies have reported essentially the same findings,[6,7] and solutions to the problem of equity of access remain elusive.

We are now facing questions in addition to the moral and ethical ones that have dominated discussions about abortion in the past. There are difficult decisions to be made about future directions in health care. Budgetary constraints now dominate the provision of all medical and health care services, and abortion services will not escape this trend. No uniform reproductive health policy has

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ever been set out in Canada; each province has been free to set its own guidelines for public health services and to make discretionary decisions about funding programs such as assisted fertility services and abortion.

Drastic changes are already occurring as the provinces and territories decide how best to allocate diminishing resources. Hospital closures, downsizing of staff and delisting of certain services and procedures have had the effect of reducing operating room hours and the availability of hospital personnel. Increased individual responsibility for payment of health care services, delays in obtaining medical services and long waiting lists for elective surgery are causing increasing anxiety among many Canadians.

Abortion services are one aspect of a wider spectrum of community programs that address healthy sexuality under the mandate of public health. Education, counselling and clinical programs relating to birth control, the detection and treatment of sexually transmitted diseases and sex education are unlikely to escape the changes that are occurring in public health. These programs will be competing for scarcer community tax dollars with services for elderly people, home care and prevention programs. Programs likely to be funded through municipalities in the future will also be competing with welfare and day-care services, which benefit women and children. Politicians who make the ultimate financial decisions will no doubt be most comfortable supporting services that, unlike abortion, are uncontroversial.

Instead of continuing to explore current patterns of access and delivery with respect to abortion we should be looking for ways of delivering these services that will ensure their continued availability. Until now, abortion services have been provided predominantly by gynecologists in large teaching and community hospitals. Hospital rules and guidelines have determined who has operating room privileges; safety (which is determined by the skill and experience of the physician) and confidentiality have been the primary concern in determining which practitioners were granted these privileges and where procedures could be performed. Although these factors will remain a primary concern, advances in surgical techniques, improvements in anesthesia and the acceptance of medically induced abortions will permit abortions to be performed in new settings. Moreover, as abortion services move from a hospital or clinic setting to other ambulatory care sites the role of the gynecologist may change from primary provider to consultant. To ensure that abortion services continue at least at the present level, alternative means of providing the same quality of service, the same confidentiality and the same level of practitioner competence need to be seriously explored.

Unlike other medical and surgical procedures, abortion services require incentives and guarantees of protection for providers. It is no longer sufficient to offer a procedural fee only. To encourage physicians to perform abortions in settings beyond the hospital and clinic, consideration should be given to providing financial compensation to cover staffing, supplies and equipment. Changes in legislation and cooperation from the local police may be required to guarantee the personal safety of staff and patients.

Moving abortion services into private clinics, community health centres and private physicians' offices and involving more general practitioners in these services will require major changes in the delivery of women's health care. Instead of conducting further surveys to determine why some gynecologists continue to perform abortions in the face of harassment, opposition and threats to their lives and practices, we should be asking whether these highly trained surgeons are the most appropriate providers. Instead of continuing to map out paths of access by community and size of hospital we should be considering whether secondary or tertiary care hospitals are in fact the best settings for these services.

In 1993, about 1 in 4 abortions were performed in specialized clinics by general practitioners. Because of a lack of consistency in the reporting of abortion statistics, the actual number of abortions performed in clinics can only be estimated. In 1997 the number of clinic abortions to hospital abortions may be closer to 1 in 3. Clinic abortions have been shown to be as safe as those performed in hospitals and to be more timely. There are now 32 abortion clinics in 8 provinces, the exceptions being Saskatchewan and PEI. In half of the other provinces women must pay for the procedure. In BC, Alberta, Ontario and Quebec, abortion clinics receive full funding and the costs to women are covered.

Medically induced abortions have become an option for more women in Canada during the past year.[8] When mifepristone (RU 486) becomes available in Canada medical abortions may account for as many as half of abortions performed.[9] Medical abortion is not currently included in any provincial fee schedule. A greater number of visits are required for screening and counselling before medical abortion than before surgical abortion, and postabortion follow-up is essential;[10] however, much of this care can be provided by nurses and other support staff rather than by physicians.

All abortions, whether surgically or medically induced, and whether provided in hospital or in another setting, should be an acceptable and integrated part of our health care system. Access to abortion should not be determined by where a woman lives or whether a gynecologist is available. All Canadian women should have equal access to abortion services.

Over the past 30 years Dr. Henry Morgentaler has fought across the country and in all levels of the courts to

ensure that women will have access to abortion. As a result, changes were made to abortion legislation and new patterns of delivery evolved. Today, more than ever, we need the vision and sacrifice of crusaders like him.

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