# Abortion Programs in New York City: Services, Policies, and Potential Health Hazards

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*A survey of abortion facilities in New York City revealed the existence of adequate resources for both early and late terminations of pregnancy. Several important weaknesses have been noted which can be related to the policies and practices of the performing institutions: less than adequate provision of postabortal contraceptive care, and counseling, primarily in private hospitals; wide variation in restrictive admission policies to minors; and substantially higher costs in private facilities.*

*On the whole, private patients are more likely to be receiving less than adequate care than non-private patients with respect to counseling and contraception. This has implications for several long-term risks, namely: repeat and recurring abortion with the possibility of increased risk of premature delivery or spontaneous abortion, and other hazardous outcomes of pregnancy.*

## Introduction

Liberal abortion is a progressive social-health measure of great importance.

In the first two years after New York State passed its liberal abortion law an estimated 402,000 abortions were performed in New York City (Pakter et al., 1973). Up to the present over 600,000 interruptions have been done in the city. By 1971, the second year of liberalization in New York, the free-standing abortion clinic, in response to demand, had emerged as a new facility, but by 1972, the third year of the new law, some clinics were already going out of business.

In 1972 there were 97 health facilities providing elective abortion in New York City: 21 free-standing clinics, 15 governmental, 40 voluntary, and 21 proprietary hospitals. Together, they performed over 200,000 abortions in calendar 1972. Legal abortion has significantly reduced maternal mortality (Tietze and Dawson, 1973).

Therefore hospitals and clinics have a public responsibility to provide this service and to make safe abortion as widely accessible as necessary.

First, then, we want to know how well the elements in the medical care delivery system are fulfilling this responsibility. Thus, we examine and report on the policies and programs of abortion facilities in this regard.

Next, we recognize that widely available abortion, while the solution to one set of social health problems, results in turn in new problems. Thus, we are concerned with repeat and recurrent (habitual) abortion and relationship between provision of contraceptive services at abortion facilities and abortion recidivism.

Will abortion on demand result in poorer contraceptive behavior and repeat abortions? Stated another way, will abortion become a major means of fertility control, supplanting contraception? In a recent study reported by Bracken et al. (1972a) based on a New York clinic, they believe their data fail to support this hypothesis, although evidence from abroad does. Reports from Japan (Burch, 1955) Latin America (Goldsmith, 1973) and from Europe (Lerner, 1971a) suggest that in particular where contraceptive programs are weak, abortion becomes the major means of fertility control; with probable increased long-term risks to women's health. Therefore, as a first step, prior to collecting patient-based data on repeat abortion, we examined and report on provision of counseling and contraceptive services to abortion patients.

Our major conclusions are:

—Voluntary hospitals are still reluctant to perform abortions. They have most resources, but they do fewest abortions.

—They are weakest in offering counseling and contraceptives. Their explanation is that they mainly serve "private" patients for whom the private physician rather than the institution should take this responsibility. This view is questionable.

On January 22, 1973, the Supreme Court of the United States

ruled that during the first trimester " 'the abortion decision and its effectuation must be left to the medical judgment of the pregnant women's attending physicians.' After the first trimester 'the state, in promoting its interest in the health of the mother, may if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health' " (Tietze and Dawson, 1973:8). Thus, after a century and a half of severe legal restrictions, it became theoretically possible to obtain a legal abortion in any state in the union.

However, "by late 1973, the decision of the Supreme Court had not yet been fully implemented throughout the U.S. In several states, the legislature, the Attorney General, or other law enforcement officers, as well as many hospital boards and hospital administrators, have taken a variety of actions designed to delay implementation, some of which have already been challenged in courts and will doubtless be declared unconstitutional in due course. At the same time, efforts are being made in the Congress of the United States to initiate a constitutional amendment which would nullify the decision of the Supreme Court" (Tietze and Dawson 1973:8–9).

If we accept the assumption that legal abortion, in effect, replaces illegal back-door abortion, and that women have the right to control their own fertility, we are recognizing that abortion on demand is an important and progressive social health measure. It follows that we should study abortion services in order to assess the nature of the services, and thus evaluate the service contribution by the major components of the health care delivery system to try to see what new health problems are being created by the availability of abortion on demand, *and by the way it is being practiced.* This study was undertaken to survey two critical aspects in the delivery of abortion services.

1. To what extent is the health service delivery system accessible for interruptions of pregnancy? How do the hospitals and clinics reinterpret the New York State law in their policies for admission to their abortion services? Are there important differences among the municipal, voluntary, proprietary hospitals and free-standing clinics in the way admissions are controlled and services provided to service and private patients?

Access to services is controlled not by patients but by professionals,

and involves the policies, practices, and procedures of health agencies. If abortion on demand is regarded as one of the essential supplementary methods for avoiding unwanted children, especially among the young unmarried; for reducing maternal mortality and for reducing premature and out-of-wedlock births, and these are recognized as important health objectives (Commission on Population . . . , 1972:97, 102–104) then it follows that equal access to abortion care regardless of age, race, marital status, religion, or socioeconomic status is imperative.

2. To what extent are abortion programs supported by other essential health and educational services by the several types of providers? The provision of contraceptive services at the time of abortion may well diminish the risk of repeat and recurring abortion. Of importace is whether contraceptive services are a regular feature of abortion programs, empathetically offered to all abortion patients, and employed by the facility in a systematic attempt to forestall future unwanted pregnacies and recurring abortions. To help us understand if ease in obtaining an induced abortion affects contraceptive practices of women, and if contraceptive practices inturn affect abortion behavior, baseline information is needed on the extent to which contraceptive services are avilable to abortion patients at the time their pregnancies are interrupted. Evidence exists that provision of contraception in the immediate postpartum period assures a high measure of acceptance by the patient (Rovinsky, 1972; Shulman, 1972).

The present work reports on a survey (see methodological note in Appendix) of all abortion facilities in New York City, undertaken and completed in late 1972 through early 1973. Its aims were to collect baseline data on the major components of the health care delivery system, that is, free-standing clinics, municipal, voluntary, and proprietary hospitals. Data were collected on the number of cases and class of patient (i.e., service and private); abortion procedures available; contraceptive services available to abortion patients; abortion counseling; and social and administrative policies regarding admission, especially in relation to minors and fees.

In 1972, as noted earlier, there were 97 health facilities providing elective abortion in New York City; 21 free-standing clinics, 15 governmental, 40 voluntary, and 21 proprietary hospitals. Together, they performed over 200,000 abortions in calendar 1972.

## Facilities

Municipal hospital services are theoretically available to all residents of New York City. The vast majority of municipal hospital patients are defined as "service" patients (in this study), as they are admitted through an outpatient department, and the major responsibility for their care, and the setting and collection of the fee, rests with the facility rather than a practitioner. Most municipal hospitals offer both ambulatory (the patient is admitted and discharged in the same day) and inpatient services, depending on the patient's diagnosed weeks of gestation and medical history. In 1972, municipal hospitals performed 12.49 percent of the abortions reported in New York City.

The voluntary hospital sector, composed of 80 licensed facilities, is by far the most numerous and best-equipped group of hospitals in New York City's medical care delivery system. As tax-exempt agencies, voluntary hospitals have a responsibility to public service; like municipal hospitals they accept service patients. However, the majority of their abortion patients are "private" patients admitted through private physicians with staff privileges at the particular institution. Most voluntaries offer both ambulatory and inpatient services. Despite their numbers and capacity, voluntary hospitals accounted for only 11.99 percent of the abortions performed in 1972.

Proprietary hospitals are operated for profit. As commercial agencies, they are relatively free to select patients on the basis of criteria they set. Patients of this sector are almost exclusively "private" (87.9 percent). This class of hospitals was the first to provide abortion services in volume, offer a wide variety of abortion procedures, and develop strategies for managing a large abortion case load. Most proprietary facilities offer both ambulatory and inpatient services. In 1972, proprietary hospitals accounted for 26.5 percent of the abortions performed.

Free-standing clinics are specially licensed facilities which offer ambulatory services to first-trimester abortion patients exclusively. The majority of free-standing clinics are proprietary facilities which serve both private and service patients. But the predominant pattern among the proprietary and voluntary clinics (of which there are three) is to manage all patients uniformly—regardless of route

of referral. The free-standing clinics took a longer time to "gear up" than the proprietaries, but once in operation they surpassed all other types of facilities in the volume of procedures performed and development of specialized abortion programs. In 1972, they accounted for almost half (49.29 percent) of all abortions performed.

## Week of Gestation

Obviously, it is desirable for abortion to be done during the first trimester because that is the period of least risk, although Tietze and Lewit (1971) have suggested that within the first trimester there is an optimum period of safety between the seventh and tenth weeks. About 80 percent of all abortions in New York City are done in the first trimester, reflecting an improvement from the first year of the law, when it was 74 percent. This shows earlier application for abortion mainly by residents. Twenty percent of non-residents have continued to seek late interruptions, possibly as a result of difficulties in making arrangements, travel, and so on.

The 16 percent of residents who continue to seek late interruptions may reflect differences in access to services attributable to age restrictions and socioeconomic status. Minors (as discussed later) may experience delays going through special procedures or searching for a facility that will accept them without parental consent. Service patients at municipal and voluntary hospitals sometimes becomes enmeshed in scheduling by bureaucratic bottlenecks that delay them past the first trimester limit and require their waiting until the sixteenth-week gestation for the saline procedures.

A health facility has a responsibility to refuse to perform an abortion beyond the first trimester if it does not have the required competence. However, between the honesty of this position and the use of gestational limit, primarily to restrict admissions, lie many variations in practice among abortion facilities.

Forty-four percent of facilities in New York City, including all of the free-standing clinics, limit admissions to the first trimester. Another 33 percent will accept service patients up to the twentieth week while 22 percent will accept service patients up to the limit, the twenty-fourth week. The picture with private patients is somewhat different. Forty percent will take patients up to the twentieth week, with a proportion, 16 percent, accepting them up to the twenty-fourth week. We found that a smaller proportion of proprie-

taries and voluntaries will accept service patients than will accept private patients up to the twentieth week. With respect to terminations up to the twenty-fourth week, the reverse is the case—a larger proportion of proprietaries and voluntaries will admit service patients than will admit private patients up to the twenty-fourth week.

In spite of these variations, it appears that a sufficient number and types of health facilities are available to provide interruptions of pregnancy to both service and private patients at almost any time up to the twenty-fourth week of gestation.

## Abortion Counseling

Clinical experience teaches, and numerous studies have confirmed, that nearly any medical procedure, but especially surgery, will generate anxiety in the patient which is likely to be detrimental to effective treatment and speedy recovery. This provides the rationale for abortion counseling.

A generally common complaint is that doctors clothe their work in a mystique and do not adequately communicate with patients. With increasing frequency one hears it demanded of the medical profession that patients be told what they are facing, what to expect during treatment and afterward. This demand has been part, not only of the movement to legalize abortion, but also of the attempt to guarantee the establishment of high-quality and humane abortion services. Abortion advocates, many of whom are part of the women's liberation movement, have insisted that counseling is essential in an abortion program to dispel traditional fears and to overcome the burden and trauma to women of violating the enormous social taboos that have prevailed in our society against interrupting pregnancy.

The involvement of women's liberation both in the struggle to win legal abortion on demand and in the actual establishment and operation of many new clinics has assured that abortion counseling has become an integral part of many programs. Anyone who visits one of the new free-standing clinics will immediately become aware of the special role played by counseling and counselors in the program, and the particular pride with which administrators and other staff in some places refer to the fact that every patient is counseled; that every patient is helped through the abortion procedure by a counselor and is treated with dignity as a patient and as a woman.

This is, we believe, all to the good, and it is within this context that our data on counseling are discussed.

Full-time abortion counselors are always women, and many facilities will employ only women who themselves have experienced at least one abortion. In an earlier study we established that when the new law went into effect in New York State in July 1970, 62 percent of all obstetricians in the state provided counseling, and of those, 38 percent felt it to be a burden on their practices (Lerner, 1971b). By January 1971, only six months later, these figures had dropped to 53 percent and 17 percent (Wassertheil-Smoller et al., 1973). Fewer physicians now provide counseling and fewer find it burdensome, perhaps because, as time went on, the facilities performing most abortions provided specialized staff who shouldered this burden.

In 62 percent of facilities providing care for service patients, professional counselors were present; service patients in these facilities accounted for nearly two-thirds of all interruptions of pregnancy in New York City in 1972. In addition, nearly 40 percent of facilities serving private patients provided professional counseling. Thus, most patients receiving abortions in New York City probably received professional abortion counseling. However, the striking fact to emerge here is the weakness in providing counseling to private patients, especially those served in the voluntary and proprietary hospitals. Many more voluntary and proprietary hospitals provide professional counseling to service patients but not to the private patient. This is because the institution has undertaken responsibility when there is no private physician. Only six among 36 voluntary hospitals (16.7 percent) and nine of 20 proprietary (45 percent) offer professional counseling to private patients.

Counseling is not merely a matter of helping patients through the trauma of an abortion, or improving their ability to cooperate with medical personnel and thereby receive beter medical care. Good counseling is integral to the question of avoiding repeat and repeated abortions, and as such becomes a necessary component in preventive and comprehensive care. In most facilities with professional abortion counseling, contraceptive education is also part of the counselor's job. Discussion of contraceptive methods, graphic illustrations of basic reproductive physiology, and helping women to decide on a method are usually a part of the counseling program.

## Contraceptive Services

We collected a variety of data on the contraceptive services available to abortion patients, including the nature of personnel providing contraceptive counseling, the setting (group or individual) and program setting in which the information was provided (as part of the abortion program or a separate program), the cost, and whether or not patients can return to the facility for continuing care. From these data we established four classes of contraceptive service. They are:

1. Facilities which offer services as a part of the abortion program at no extra cost; which supply all methods; where patients can return for continuing care (the best).
2. Offer above as a separate program, or at additional cost, or offer less than a full range of methods and services
3. Information only
4. No information or services (the least)

These "classes" of care were reviewed as they applied to private and service patients served at each of the four types of facilities. The difference between contraceptive care provided to service patients and private patients is even more striking than that observed in abortion counseling. While 60 percent of the facilities providing contraceptive care to service patients are classed as "best," only 20 percent of private facilities are so classed. The municipal hospitals take the prize here for both classes of patient with 100 percent coverage. At the other extreme, nearly 60 percent of voluntaries are in class 4, "the least," providing no contraceptive services to private patients at all, not even information.

Only 41–46 percent of the free-standing clinics are included as class 1, "the best," in contradistinction to their provision of other abortion services, which is generally quite good. We had to classify a number of them as Class 2, since they do not provide adequate continuing contraceptive care (revisits). This is because most of their patients are out-of-state residents who will not return to the clinic for revisits. These patients are urged to see their own physicians at home. On balance, as a group, however, the free-standing clinics are second only to the municipal hospitals in their provision of contraceptive services, since virtually all of them fall into Class 1

or 2 for service patients, who account for four-fifths of their case load. The private hospitals also score high for service patients when classes 1 and 2 are combined, but these categories account for only one-fifth of their case load. On the other hand, in private hospitals rendering contraceptive care to private patients, 80 percent of their case load, we find only about one-third falling into classes 1 and 2 combined. All facilities provide something to service patients.

It is established in the birth control field that contraception, when offered immediately postpartum, is more readily accepted by patients, and more effectively employed subsequent to discharge. Having an abortion is a closely analogous situation, where it can be assumed that readiness to accept contraception is, if anything, even more likely than at delivery since the primary objective of the patient was to terminate a pregnancy. Evidence is available that giving contraceptive information, education, demonstration; offering a choice of methods; helping the patient to decide on a method appropriate to her life style and point in the life cycle; concluding with actual prescription in the form of a supply of pills, installation of an intrauterine device, or fitting with a diaphragm provided at the time of delivery are medically safe and promise most chance of success in future contraceptive behavior (Shulman, 1972). A common finding on family-planning services is that 25–50 percent of patients fail to respond to referrals. Hence, any abortion service that sends the patient to another location for contraception and delays the performance of this service to a later visit is going to lose a large number of patients. Similarly, offering less than the full range of methods or imposing additional charges will deter some patients. Finally, follow-up care is absolutely essential in relation to contraception. The possible risks to health from the various methods are well known, not to mention the hazards of unwanted pregnancy from improper use of a method. We found a serious weakness in the health delivery system with respect to continuity of contraceptive care for abortion patients. All facilities classed 2, 3, or 4 fall into this category. That includes 80 percent of those treating private patients and 40 percent of those treating service patients.

## Admission Policies of Abortion Facilities

Health facilities generally control admissions. In a society such as ours where provision of medical care is largely private, hospitals

and clinics have traditionally enjoyed wide discretion in accepting or excluding patients. Admission policies to hospital or clinic care involve a number of complex considerations which we need not review here. In relation to abortion, however, the question of whether the facility should have exclusive right to control access to service is an explosive issue far exceeding in volatility the usual arguments about access to medical care. Indeed, almost anything that attaches to abortion is likely to be inflammatory.

Short of a national system of medical care (which hopefully, will more clearly define the authority and responsibilities of health care facilities and professionals, as well as the rights and obligations of patients) individual health facilities, particularly in the private sector, will continue independently to define their social obligations to the community in rendering care. They have few other alternatives. However, this does not obviate the fact that when facilities make their own decisions regarding the delivery of health care, within a context of relative anarchy, they often make decisions which appear necessary and rational (to the provider) but may be antipathetical to the patients and the community. Such is often the situation with respect to the admission policies of abortion facilities. Surely, abortion facilities should be free to refuse patients admission when they have no room, or when they lack competence in a procedure. But should they also be permitted to refuse admission because they don't like abortions, or because they believe too many abortions will tend to denigrate the reputation of the obstetrics-gynecology department, or because they are loath to perform an abortion on very young unmarried women? These, after all, are social rather than medical questions. There is no question that this area is replete with many social complexities, and, indeed, even legal ambiguities, when it comes to the rights of minors. Ultimately, society will work out answers to these questions. In the meantime, we have data on several important dimensions that tend to affect access to abortion services.

### *Residence*

Residence restrictions are not stringent, although they are noticeably more lenient for paying patients. Of the 75 facilities which accept private patients, 74 have no residence restrictions. One voluntary hospital requires that patients live in the hospital district. Of the 63 facilities available to service patients, 54 (85.7 percent)

have no restrictions. One proprietary hospital requires that service patients live in the region; five municipal hospitals require that service patients live in New York City; one municipal hospital requires that service patients live in the hospital district. In fact, however, access to these facilities is not seriously limited by residence because most hospitals, even in these instances, do not scrupulously check proof of residence. The means used to vouch for residence are sufficiently casual so that there is little actual restriction. On the other hand, any restriction may tend to discourage some women who need care.

### *Husband's Consent*

We inquired regarding the requirement for the husband's consent and found that only four voluntary hospitals impose this constraint.

### *Restriction to Minors*

One of the important ways in which an abortion facility can restrict those it serves is by requiring parental (or guardian) consent from those it defines as minors. Whereas the historical definition of majority has been age 21, today, with the 18-year-old eligible for military service and able to vote, and with our society's greater sexual freedom, there has been a practical lowering of the threshold defining majority. However, despite these changes majority is not so clearly defined. Thus, facilities continued to define it by their own lights.

We asked facilities at what age (if any) they *required* parental consent, as a practical way to get at their definition of minority. While the modal age (and below) for which facilities require consent was age 17 to 18, there is a spread across the entire range, from no limit to age 21, regardless of type of facility or class of patient. The majority of facilities (82.6 percent) require parental consent for patients under 17, 18, or 19 years of age, depending on the individual hospital or clinic. Five facilities (6.7 percent) require parental consent for private patients 19 to 21 years old.

Municipals adhere quite literally to city policy which does not require parental consent above age 18. However, it must be noted that several factors operate which result in the rules being more liberal than is apparent. First, discretion is exercised by staff if they believe disclosure to a parent will seriously traumatize a minor. Almost any minor, even a very young one, may receive service at a

city hospital regardless of the age at which the facility may define minority, if she is "emancipated" (i.e., one who is married or economically independent and living away from home), or has had a previous pregnancy or abortion. Finally, proof of age required by facilities varies considerably from quite casual to very rigid.

Voluntary and proprietary hospitals have the most age restrictions. Both categories have hospitals which require parental consent for abortions for patients up to 21 years of age. While approximately one-third of the free-standing clinics have no age restrictions at all, some of them require parental consent up to 19 years of age. The municipal hospitals have the fewest age restrictions. Some of them have no age limits at all, and the rest require parental consent only for patients under 17 or 18 years old.

Free-standing clinics as a group have the most liberal policies with respect to minors. Five of the 15 free-standing clinics reported no restrictions. None required parental consent for patients 19 to 21.

The majority of facilities accepting service patients require parental consent for patients under 17, 18, or 19 years of age (82.5 percent). Only two voluntary hospitals (3.2 percent of the total) require parental consent for service patients 19 to 21 years of age. Parental-consent requirements for private patients are similar to those for service patients but somewhat more restrictive. Only 18 (10.7 percent) of 75 facilities accepting private patients for abortions have no age restrictions. These include five free-standing clinics, two proprietary hospitals, and one voluntary hospital.

Despite the fact that requirements of proof of age or emancipation tend to be flexible in many facilities, admission of minors is often quite subjective. It is our judgment from an analysis of responses that the great majority of abortion facilities tend to moderately restrict and discourage minors applying for an abortion, although none categorically refuse to perform interruptions on minors. Only in a small proportion are they admitted without restrictions; and in a few, mostly private, facilities, they are strongly restricted and discouraged. Beyond the statistics, however, it must be noted that any restrictions may act as a deterrent in preventing an unknown number of younger women from even applying for an abortion. The fear of having to meet a series of difficult qualifications, including possible threat of disclosure, when added to the anxiety of the unwanted pregnancy, may well be too much for some younger women.

## Cost of Abortion

Our data permit the calculation of the average total cost of an abortion by type of facility, procedure, and class of patient for New York City in 1972. Included are any extra charges such as rho gam (immunization against the rh negative blood factor), lab fees, and the like. The cost of an abortion is higher for a private patient than for a service patient for all types of interruptions. The difference in increase for private patients in total average cost is approximately $50.00 for D&C or for vacuum aspiration with and without curettage, and $15.00 for a saline procedure. For all four types of interruption, the cost is significantly higher in voluntary hospitals than in the other three types of facilities. For service patients the range of average cost varies by type of facility by more than $100.00 for all procedures except saline interruptions, where the average cost ranges from $309.00 to $368.00, a difference of $59.00. The average cost of a D&C for a service patient varies by type of facility from $139.00 to $263.00, a difference of $124.00.

Vacuum aspiration with curettage costs from $141.00 to $244.00, a range of $103.00, while vacuum aspiration without curettage costs from $119.00 to $269.00, a difference of $150.00. For private patients the range of average cost for a D&C and for vacuum aspiration with and without curettage varies by more than $60.00 to $80.00, depending on the type of facility. The average cost to a private patient for a D&C ranges from $210.00 to $272.00, a range of $62.00. Vacuum aspiration with curettage costs from $200.00 to $270.00, a range of $70.00. Saline procedures range from $252.00 to $385.00, a difference of $133.00.

In summation, the average costs for private patients are higher than those for service patients, although the variation in average costs by type of facility is greater for service patients than for private patients. Vacuum aspiration with curettage, the most frequent procedure, is the least expensive method on average. For service patients, the municipal hospitals provide the lowest set of charges; for private patients, the free-standing clinics average the least cost to the patient. For both classes of patient, the voluntaries are the most expensive. Most likely this is a major factor in explaining why the voluntaries do so few abortions relative to their size.

The assumption set forth in the introduction—that legal abor-

tion will replace illegal abortion—is at least in part based on the rapidly decreasing cost of the legal procedure. The reduced cost not only brings safe abortion within the reach of many who could otherwise not afford it, but also helps to assure privacy from family and others when a woman feels that privacy is crucial to her well-being. Most women or couples can manage to raise the $160.00 or so needed for an early abortion in a municipal hospital or free-standing clinic without disclosure.

## Discussion

Induced abortion on such a large scale is a very recent phenomenon in the United States. There are indications, however, that it will continue and grow. Presently, there are sizable gaps in knowledge about many aspects of abortion. New York City is a particularly suitable research locale to fill some of these gaps because of the large number of abortions performed there as well as the heterogeneity of the population served. In view of the recency of permissive abortion statutes it is not surprising that we are just beginning to accumulate research data that describe the universe of American women obtaining abortions. Also scanty are data on the cumulative social, contraceptive, and fertility experience of women, postabortion, on the frequency and causes of repeat abortion, and on the long-term health hazards from exposure to repeat abortions.

The experience in New York City, as reported by the Health Services Administration (Chase, 1972), indicates that abortion can be done safely on a large scale. The HSA report further indicates that abortion has not swamped the health system as was originally feared; moreover, mounting evidence is emerging of a favorable impact on reductions in maternal mortality, out-of-wedlock births, and prematurity. Legal abortion appears to have replaced illegal abortion. "Data from ten reporting municipal hospitals show a sharp drop in incomplete and spontaneous abortions, from 415 per month in Year 1 of the law to 220 per month in Year 2. Since the number of spontaneous abortions was likely to remain relatively constant, it is likely that this reflects a true decline in the number of criminal abortions" (Chase, 1972:3; Pakter et al., 1973).

However, legal abortion as the solution to illegal abortion brings in its wake a new set of problems requiring solution. These

may not be the problems initially envisioned (i.e., capacity to meet demand, protection of the patient from early complications, disapproval of the obstetrical profession) but other equally serious issues. What are some of these issues?

Will abortion on demand result in poorer contraceptive behavior and repeat abortion?

Evidence to date also suggests that about 40–80 percent of those coming for interruptions of pregnancy were not using any means of contraception at the time they became pregnant (Bracken et al., 1972b; Corson and Bolognese, 1972; Diggory, 1969; Grauer, 1972; Pion et al., 1970; Steele, 1966). The question therefore is: How will this behavior continue to be affected by easier access to legal abortion and how will it be influenced by exposure to contraceptive services? Will the number of unwanted pregnancies increase or decrease for women who have had induced abortions?

In Eastern and Central Europe, where abortion has been easily available for some time, it has apparently become the chief means of fertility control and attempts to develop national acceptance of contraception have not been widely successful to date (Lerner, 1971a; Szabady and Klinger, 1970:31–43; Klinger and Szabady, 1969:68–76; David, 1970).

In Hungary, for example, easy access to abortion has apparently led some women to terminate pregnancy by this method, 10, 20, and even 40 times. There is great concern with this group of high-frequency users, since Hungarian data tend to support the hypothesis that three or more abortions significantly increase the risk of ectopic pregnancy, premature delivery, and spontaneous abortion, and are suggestive but not conclusive of excess sterility (Lerner, 1971a; Hungarian Central Statistical Office, 1970:18–35). Similar results have been found in Czechoslovakia (Cernoch, 1968; Kotasek, 1971) and Britain (Liu et al., 1972).

A recent study in the Soviet Union found that extensive contraceptive services resulted in reduced abortion among women who previously had used no contraception (Verbenko et al., 1965). Studies in Holland found a similar result (Van Emde, 1965).

Tietze (1973:41), citing data from New York City in the past two years, states: "Indirect evidence suggests that, overall, contraceptive practices improved markedly between the first and second years of the liberalized abortion law." Diamond et al. (1973), citing data from Hawaii, can find no evidence that easy abortion re-

sulted in *less* contraception, but found that a *continuing rate of two-thirds* of the women coming for abortion were not using contraception at the time they became pregnant. Thus, they concluded, abortion has not improved contraception use. Daily and Nicholas (1973) found that the rate of repeat abortion, despite some exposure to contraception, has increased from 0.5 percent in 1970–1971 to 6 percent in the first six months of 1972, and notes that these figures are probably a substantial underestimation. Study of a small group of repeat abortions by Daily revealed that 47 percent of the women reported no use of contraception prior to the repeat abortion. Moreover, 59 percent of the repeaters left the hospital without being started by the staff on the contraceptive method they had requested.

Limited data are now available from New York City which indicate a 5 percent abortion rate within twelve months in one municipal hospital, in spite of this population's exposure to intensive family planning at the time of abortion (Rovinsky, 1972). In this study it was found that, while all patients were exposed to contraceptive education and prescription, nonetheless institutional failure to provide the method of choice selected by the patient, or confusing referral information, were important reasons for contraceptive failure, resulting in a repeat abortion. Other reasons for repeat abortion were true contraceptive failure and motivational failure on the part of some patients.

Kantner and Zelnik (1973) in studying a national sample of young unmarried women, age 15 to 19 in the United States, found that 28 percent reported having had sexual intercourse and 53 percent of these had used no contraception the last time they had intercourse. Correlated with this is the fact that only 40 percent had a generally correct idea of the period of greatest risk of pregnancy.

As Campbell (1968) and Coombs and Freedman (1970) have written, the timing of a first pregnancy can have lifelong consequences to a young women or a married couple. Therefore, follow-up data on first abortions could materially assist in predictions of social, economic, and health consequences for these women. For example, if failure to use contraception effectively were an etiologic consideration in the abortion rate for specific groups of women, we would expect to be able to predict, from the contraceptive behavior of these young women in the postabortion period, the risks of future abortions.

If abortion on demand is regarded as one of the essential supplementary methods for avoiding unwanted children, especially among the young unmarried, for reducing maternal mortality, and for reducing premature and out-of-wedlock births, and these are recognized as important health objectives (Commission on Population . . . , 1972:97, 102–104) then it follows that equal access to abortion care regardless of age, race, marital status, religion, or socioeconmic status is imperative. However, the relationship between liberal abortion and contraceptive behavior, as judged by available data, is unclear. Direct and unequivocal evidence on this relationship is not yet available, especially for the United States.

## Conclusions

The voluntary and proprietary hospital systems maintain policies with respect to admission which tend to discourage minors, in some instances requiring husband's consent. The fees at these institutions are substantially higher for both early and late interruptions of pregnancy. This also tends to discourage poorer women. Moreover, their lack, as a class of institutions, in providing adequate contraceptive services—some not even providing contraceptive information—has an important bearing on the probability of repeat and recurrent abortion, which in turn has implications for future hazardous outcomes of pregnancy. Further, while it has not been discussed in this report, the voluntary and proprietary hospitals continue to perform a high proportion of interruptions of pregnancy by the method of dilatation and curettage, a method that has been shown to carry a higher risk of early (and possible also late) complications (Tietze and Lewit, 1971). We therefore conclude that the voluntary and proprietary hospital systems could materially improve the present quality of their abortion services both with respect to access to service, improved counseling, and contraceptive services.

Municipal hospitals, on the other hand, provide more comprehensive services at lower fees, with no serious limits on access to services. The free-standing clinic system presents no bars to access, asks reasonable fees, but is lacking in contraceptive follow-up, primarily because the vast majority of their patients are from out of state.

# Appendix

## *Methodology*

The present work reports on a survey of all abortion facilities in New York City, undertaken and completed in late 1972 to 1973. Its aims were to collect baseline data on the major components of the health care delivery system, that is, free-standing clinics; municipal, voluntary, and proprietary hospitals. Data were collected on the number of cases and class of patients (i.e., service[1] and private); abortion procedures available; contraceptive services available to abortion patients; abortion counseling; social and administrative policies regarding admission, especially in relation to minors; fees; and readiness to collaborate with us in the planned prospective study of the patients.

This report presents data on each of these aspects, except the last.

Survey was by telephone interview, subsequent to an explanatory letter to the chief of Obstetrics and Gynecology and the hospital administration on stationery of the Albert Einstein College of Medicine. Field work was by experienced medical interviewers under our direct supervision.

The survey schedule was developed by the principal investigator and pre-tested in June 1972 in 20 randomly selected facilities in New York City.

Construction and pre-coding of the final interview schedule was assisted by a senior staff member of the National Opinion Research Center of the University of Chicago (New York Office). The interview schedule is pre-coded except for a few items. All editing and analytic coding was done directly by the principal investigator. Tabulation was done at the Health Sciences Center of the State University of New York at Stony Brook.

The primary informant in the facility survey was the chief of

[1] Service includes "non-private" clinic patients, i.e., patients who were admitted without a private physician. Tietze and Lewit (1971), for example, have chosen to class these clinic patients as private, primarily because they paid a fee and were not financially classed as "service" cases. We class them as service, in the sense of non-private, because they did not have a private physician for the abortion.

Obstetrics and Gynecology or the medical director of the abortion service. Supplementary information was often provided by administrative personnel.

Field work was conducted from November 1972 to February 1973. Contact with the primary respondent was established in one to five telephone calls in 44 percent of cases, and within six to 10 calls in 30 percent. The remaining 26 percent of facilities required 11 to over 20 calls. However, persistence has its reward in high completion rates. The interview was usually completed during a single final telephone call. Most respondents were extremely cooperative. Eighty-five percent of interviews were completed within 40 minutes. The remaining 15 percent required up to one hour.

The number of abortions reported to us on survey by each facility was validated against two independent sources for the same data:

1. New York City Health Department reports of number of abortions, submitted weekly by each facility[2]
2. New York City Health and Hospital Corporation statistics service reports, collected independently by the Corporation for each municipal facility

Among 136 hospitals in New York City nine state and federal institutions are excluded, since they perform no abortions (except for the State University Medical School Hospital of the Downstate Medical Center, which is included under Municipal). Of the remaining 127 hospitals only 76 have an abortion service. The 51 institutions that do not perform abortions are Catholic hospitals, geriatric facilities, or facilities that perform so few elective abortions that they need not be counted. Thus, in gross terms, 76 among 136 hospitals in New York City, or about 50 percent, provide an abortion service. To this must be added 21 free-standing clinics, making a total of 97 active abortion facilities in New York City, calendar 1972.

Initially, 108 hospitals and clinics were surveyed, but 11 were dropped, since collectively they accounted for only 200 abortions in

[2] This is not to be confused with abortion certificates required to be filed by facilities. There is serious underreporting of certificates, possibly as high as 17 percent. The validation data come from direct reports made weekly by each facility to the abortion surveillance unit of the New York City Department of Health.

1972. Thus, our denominator was reduced to 97. In the course of the survey the denominator was further reduced to 88 operating facilities: three refused survey, three were never completed, and three clinics became operational too late in the year in 1972 for inclusion. Our completion rate was 90.7 percent. Excluding the three latecomers from the denominator gives us a true response rate of 93.6 percent. The denominator for this study is 88.

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