UNITED STATES GOVERNMENT POLICY ON ABORTION

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The nature of federal policy on abortion is explored and the need for a uniform and consistent position is emphasized

At this time, there is no uniform "federal government policy" on abortion. Instead, the policies of the various agencies exhibit a spectrum that ranges from outright endorsement to outright prohibition.

On the one hand the Department of Defense (DoD) now permits the performance of abortions for medical reasons and reasons of mental health. In July, 1970, Assistant Secretary of Defense (Health and Environment) Louis M. Rousselot determined that abortion may be performed in military medical facilities in the United States without regard to local state laws.[1]* This action is applicable, of course, only to those individuals eligible to receive care in military medical facilities.

On the other hand, the Office of Economic Opportunity has a policy guideline stating that no project funds may be used for any surgical procedure intended to result in abortion.[2] This is not a statutory limitation but an internal policy that was established when the agency initiated its family planning programs in 1965.

This policy, however, is under intensive review both as the result of changing perspectives within the agency and indications from OEO constituents that a change would be desirable. For example, a recent program management survey of OEO-funded family planning projects revealed that nearly 60 per cent of the projects wanted to be able to offer abortions to their patients.

The Department of Health, Education, and Welfare is somewhat between OEO and DoD, for HEW has no policy for or against the performance of abortion in HEW-sponsored programs. It should be noted, however, that abortion is a reimbursable expense under Title XIX Medicaid payments in those states that are enrolled.[3] In fact, abortions are being paid for under this statute in those areas such as New York where their performance is not restricted by state laws.[4]

Separate Abortion Policies

It is worth taking a moment to examine why three federal government agencies would have separate policy approaches to abortion services. To a great extent this is due to the fact that there is no clear consensus regarding this issue among the American people. While most surveys indicate a majority of the people favor legalization of abortion, there is still a sizable minority that forcefully opposes it. These groups all have ways of

expressing their views, and the extent to which they do is reflected in federal policy. Thus, to a large extent, the position of a particular agency on the question of abortion is a function of its relative accessibility to pressures of various kinds.

The simple facts of survival are that Congress appropriates money for the Executive Branch, and without money, there are no programs. In certain quarters of Congress there is firm opposition to the utilization of public funds for the provision of abortion services. An amendment to the Family Planning Services and Population Research Act of 1970 goes farther than that. The amendment states that "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."[5] The Congress clarified its intent, however, solely to be the prohibition of use of funds for the provision of abortion services.[6]

This act will have a direct effect only on HEW programs, not including Title XIX Medicaid payments. However, the lack of Congressional enthusiasm for abortion exerts a dampening influence on policy changes in more vulnerable agencies such as OEO.

The demand for public accountability is also felt directly from the electorate itself. Opposition to abortion programs comes not only from Catholics and religious fundamentalists, but from militant minority male groups making the accusation of "genocide." Thus, the ambiguity of the federal government on abortion is basically a reflection on the complexity of this issue and the lack of unanimity of will among the American public.

No Clear Mandate

In the absence of a clear mandate on this issue, there are a number of factors that federal family planning officials must heed. First, they are keenly aware of the ethical and moral considerations that confront the individual citizen making a private decision about abortion. The government, however, is not permitted to arbitrate the moral "rightness" or "wrongness" of the individual abortion question, or even of abortion itself, even though that ethical question may be of paramount importance to the individual.

A second factor concerns important legal and constitutional questions. One of these is the Griswold decision in 1965, stemming from the Bill of Rights, which upheld the right of marital privacy.[7]

Another major constitutional issue, which has been raised by the Gesell decision in Washington, D.C., is that of discrimination on economic grounds. In the Gesell decision, the court indicated that the prohibitively high cost of abortions in the community could be considered a violation of the constitutional rights of equal protection until such time as abortions are as available to the poor as they are to the rich.[8] By and large, legal abortions are easily available to the affluent but not to the poor. Even in New York, where there are few restrictions and where municipal hospitals provide free abortions for the poor, there are long waiting lists, occasional economic exploitation, and stories of women who fail to receive a requested abortion.

The third factor that federal officials must consider is the relationship of abortion to public service needs and public health considerations. It is generally agreed that one-

fourth to one-fifth of all pregnancies in the United States end in legal or illegal abortion.[9] Under these circumstances, laws restricting the performance of abortion restrict the physician's exercise of his professional responsibilities and can force him to break the law.[10] Worse yet, these restrictions have resulted in racketeering, profiteering, and exploitation by unscrupulous individuals.

Danger of Clandestine Abortion

Clandestine abortion constitutes a significant health problem affecting large numbers of people, including both the women at risk and their families. It is well known that deaths due to the effects of clandestine abortion account for a significant proportion of the maternal mortality in this country.[11] This is true even though many such deaths may go unreported or are reported under other categories.

Clandestine abortion accounts for an even larger portion of an unacceptable and disproportionately high maternal mortality rate. In 1967, for example, the rate of ***reported*** mortality due to abortion with sepsis was nearly seven times higher than among non-whites as it was for whites.[12]

In the absence of a clear-cut mandate on abortion, how can federal officials reconcile these important moral, legal, and public health considerations? In reassessing current OEO policy, we are taking several factors into account. The first is the role of abortion in the total context of health services. Our unofficial position is that abortion should be an essential part of complete family planning and comprehensive health services. If abortions are to be made available through our programs, they will serve only as a back-up for contraceptive failure or omission and not as a substitute for contraceptives. This, it is likely that abortion will be utilized primarily by women at either end of the reproductive age range.

In reassessing OEO's policy, we look to the experience of other countries with more liberalized abortion policies. From the Eastern European countries we have learned that large numbers of abortions can be done simply and safely early in the first trimester.[13] On the other hand, we know very little about the logistics of setting up abortion services or the costs that will be incurred. We need to learn more about the possible side effects of abortion, its psychological implications, and other outcomes of unwanted pregnancy.

Cost of High Quality Family Planning

The development of and adherence to the highest standards of medical care are major concerns in any such government effort. Costs are also an essential consideration, and here we must balance the comparative costs of high quality contraceptive care for a given number of women versus the costs of high quality abortion procedures for a smaller number of women. The question is, as always, who will get how much of what limited services and resources?

We estimate currently that the costs of high quality family planning services are in the range of $60 to $80 per woman per year at the project level. By contrast, abortions may

cost from $50 to $600 per case depending on local fee levels, techniques, and gestational age. Abortion as an exclusive method of birth limitation could theoretically cost up to $2,000 per year or more. It is therefore not attractive as a sole or major method of birth limitation from the point of view of cost alone.

From these figures, it is easily seen that, at current cost levels, the price of one abortion could provide family planning services for the same woman for several years. If we are to provide abortion services, then, it is clear that they should also be combined with a serious effort to provide effective subsequent contraception.

Inevitably, there will be some women in these circumstances who have used and will continue to use abortion as a sole method of birth limitation. At this point, we do not know what percentage will choose to do so. As responsible health officials, we have to consider making abortion available to these women, with the hope that continuing efforts at education and understanding can direct such women toward more desirable methods.

Given our present spectrum of federal policies, and the many factors that must be considered by the government, what steps can be taken now? At OEO, we believe that there is a pressing need to pull our various federal agency viewpoints together so that information and experiences may be shared more effectively. We have discussed this matter with Dr. Louis Hellman, Deputy Assistant Secretary for Population and Family Planning Affairs at HEW, and the office of the Assistant Secretary of Defense for Health and Environment. We have all agreed to pursue this further.

We believe that in this sensitive area, governmental policy must follow a clear mandate from the people. In no circumstances can it be coercive. Today there is no consensus, and it may be some time before the divergent viewpoints on this matter are reconciled.

Our second need is to ascertain the standards of medical care, cost projections, and logistics of providing abortion services in those programs where we are able to do so. For this reason, OEO has under consideration a request from APHA to fund the recent formed APHA Task Force on Family Planning Methods. The purpose of the Task Force is to formulate these basic guidelines and standards for program development.

At OEO, we believe these steps will help us resolve some of the very complicated issues in this very complex area of abortion service delivery.

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