Part II

Findings

Chapter 4

Induced Abortion: Classification and Number

Broad changes in recent years in the standard of living and the scope of coverage under social security and national health insurance have affected the way of family life and the health status of Canadians. While the marriage rate has remained fairly constant, the size of the population has grown and with it there has been an increase in the number of women of child-bearing age. At the same time there has been a decline in the birth rate, an absolute decrease in the number of infant deaths, and fewer mothers have died at childbirth.

As a profound social, moral, and legal issue, and one which may involve much stigma, induced abortion is an area of human concern which involves great risk of personal and collective bias influencing the approach, the interpretation, and the use of "facts". As part of a cluster of issues related to sex and the family which includes family planning, genetic counselling, out-of-wedlock parenthood, social security programs, and ultimately a potential population policy, induced abortion in this broader context has seldom been considered in a consistent manner. While induced abortion is an indisputable fact of life, the way this issue is seen by a people is reflected in the nature of a nation's laws and the types of information which are routinely collected, what is analyzed and published, and the use to which this information is put.

Bill C-150, the Criminal Law Amendment Act, 1968, was introduced in the House of Commons in December 1968. It was given Royal assent on June 27, 1969, and its terms went into effect on August 26, 1969. In 1970, the first complete calendar year after this legislation was passed, the number of reported therapeutic abortions was 11,152. By 1974 the number of reported therapeutic abortions was 48,136.

The increase in the number of reported abortions reflects a complex web of changing social forces. These forces involve gradual shifts in the age and sex composition of the population, and on occasion, almost imperceptible but shifting ideas about the relations between men and women, the bonds between children and parents, and of the role of the family in Canadian society. Changes in recent decades in where Canadians live and work and the larger number of married women in the work force have been coupled with both a higher level of education for most individuals and modified ideas about social

and religious morals. Scientific advances and modern medical technology have raised new ethical issues which require the re-evaluation of traditional professional imperatives.

As the way of life of Canadians has gradually changed, there have been shifts in their sexual behaviour and sexual norms, subjects which have not been easily and frankly dealt with in public. The idea of a social taboo, a practice which involves forbidden or prohibited behaviour, has pervaded the public consideration of sexual behaviour. There have been few inquiries and none of national scope which have dealt with the sexual behaviour of men and women, the extent of sex-related diseases, the knowledge and practice of contraception, sterility and voluntary sterilization, homosexuality, or the health and fertility consequences of these sexual experiences. The discussion of these issues in public has often been on a basis of what is held to be ideal or moral behaviour, or conversely, in terms of what is sensational, aberrant, or prurient.

It is within this context that information about induced abortion has been collected by government, professional associations, and other groups in Canada. The full story on sexual behaviour and its related health and demographic implications has yet to be told. In terms of what has not been done collectively, it appears that the health professions, demographers, and government health departments for the most part have not wanted to know about these issues and they have done little to change this situation. Most of the factual information on these subjects comes either from Statistics Canada or provincial medical and hospital insurance sources which classify morbidity records for financial accounting purposes. The few reports on abortion which have been published by government have given lean, selective, and incomplete statistics. These reports have ignored the health consequences and social essence of induced abortion for the public. A number of "confidential" reports have been prepared by different levels of government which have been made available to the Committee, but which have not been published.

The number of 48,136 reported therapeutic abortions for 1974 constitutes a minimum of the actual number of induced abortions which Canadian women had during that year. Excluded from this total were: (1) self-induced abortions which did not require further treatment in hospital; (2) abortions which were classified as "spontaneous" and "other"; (3) abortions induced illegally outside hospitals; (4) abortions obtained by Canadian women outside the country; and (5) induced abortions which were done in hospitals which were not classified as abortions. For these reasons precise information is not available on the total number of Canadian women who have had induced abortions in a given year, nor is there a reliable estimate of the total number of Canadian women who previously had abortions.

Demographic trends

According to demographic theory when a country makes the transition from an agrarian economy to an industrial society, it passes through three

stages in terms of its fertility and mortality trends. The fertility of women refers to the actual number of children who are born, while fecundity is the biological ability to become pregnant. Reflecting changes in the economy, the use of contraceptive measures, and the impact of more extensive health care, the three demographic stages are: (1) a high birth rate and a high death rate; (2) a high birth rate and a low death rate; and (3) a low birth rate and a low death rate. Implicit in this concept is the fact that when a society's way of life changes along these lines, the decline in mortality occurs before a drop in fertility, a change which usually follows after a period of time. Once a country has completed these population shifts, the demographic process is usually irreversible. The experience of most industrial western countries including Canada conforms to this pattern with the exception of the "baby boom" years following World War II.

Taking 1970 as the first full calendar year after the Criminal Code amendments on abortion came into effect, an index of 100 is used as a baseline in the review of trends in vital statistics.[1] In the five-year period from 1970 to 1974, the population of Canada rose from 21,297,000 to 22,446,300, or from the 1970 index of 100 to 105.4. In 1974 there were 5.4 percent more people in Canada compared to 1970. The number of women in the fertile age group in 1973 was 7.5 percent higher than in 1970. The number of marriages increased steadily during the 1960s and reached a high of 200,470 in 1972. This number declined in 1973 and in 1974, reversing the trend of a decade for the first time.

The birth rate for the country started to decline around 1960. By 1970 the crude birth rate per 1,000 population was 17.5, which dropped further to 15.4 in 1974. The largest decline was in Newfoundland, while Quebec and British Columbia had the lowest crude birth rates. The total fertility rate for the country dropped from the index of 100 in 1970 to 78.6 in 1974. The decline in fertility went below the population replacement level for the first time in 1972. This decline in fertility continued in subsequent years.

During the past three decades there was a sharper reduction in the number of infant and maternal deaths than in the total number of deaths for the Canadian population. These changes resulted from a combination of factors including an improved standard of living, more extensive health care, and special maternal and child health programs. From 1950 to 1964 the Canadian death rate dropped from 9.1 to 7.6 per 1,000. At the same time the number of infant deaths during the first year of life (the infant mortality rate per 1,000 live births) declined by 40.5 percent from 41.5 to 24.7. Neonatal deaths, or the number of infants dying who were less than four weeks old, decreased by 29.1 percent from 24.4 to 17.3 per 1,000 live births. These trends continued in the 1970s, with the infant death rate dropping by 20.2 percent (18.8 to 15.0) between 1970 and 1974 and neonatal deaths by 25.2 percent (13.5 to 10.1) during this five-year period.

The characteristics of women who have had reported therapeutic abortions in hospitals have been documented since 1970 in the annual reports on

[1] Experience listed above 100 (e.g., 280.0) represents an increase, while figures below the index number represent a decrease (e.g., 78.0).

Therapeutic Abortions published by Statistics Canada. The increased number of Canadian women who had reported and unreported induced abortions was a contributing factor to the general decline in the birth and fertility rates. In 1970 there were 11,152 reported induced abortions done in Canadian hospitals, a number which rose to 48,136 in 1974. If this information is considered by itself, it might be inferred that general social factors influencing the decline in the birth rate accounted for 21.6 percent of the decrease in the number of births, while the increased number of reported induced abortions between 1970 and 1974 determined 78.4 percent of the fewer births which were reported. This conclusion is invalid. It assumes full knowledge about the growing use of contraception, trends in the surgical or voluntary sterilization of men and women, and the volume of illegal and out-of-country abortions.

There is no fully accurate appraisal of how many women in the 1960s had induced abortions. From information which is available, their numbers were not inconsequential in terms of contributing to the slower rate of population growth. The usual child-bearing age for women is between 15 and 44 years and may extend for a few women to 50 years or older. The experience with induced abortion of women over age 51 is an approximate measure of the extent to which abortions were obtained in the 1950s and 1960s. Based on the findings of the Committee the rates of illegal and self-induced abortions for these women were 2.2 and 15.5 per 1,000 respectively, while the rate of induced abortions obtained in Canadian hospitals was 0.71 per 1,000. If the crude birth rate of 1970 had remained the same in 1974 (17.5 versus 15.4 per 1,000 population), there would have been an estimated 47,200 more births than the 345,645 in 1974.

The decline in the birth and fertility rates for the country, and their even sharper drop in some provinces, was influenced not only by a growing number of induced abortions but as well by a sizeable increase in the number of individuals who were sterilized.[2] The total number of reported induced abortions between 1970 and 1973 was 124,129. During the same period there were 9,880 reported male sterilizations and 244,963 female sterilizations. The rate of female sterilizations rose from 1.5 per 1,000 population in 1970 to 3.8 per 1,000 in 1973. If these rates are considered for women between the reproductive ages of 15 and 44, the rate rose from 7.1 per 1,000 to 17.4 per 1,000 during this period. There were considerable provincial variations in the rates of sterilization. In 1973, 5,065 women who had induced abortions (11.7 percent of women obtaining reported induced abortions) were concurrently sterilized; 94.0 percent of the 84,941 women who were sterilized that year had this operation done as a separate procedure.

The increase in the number of reported induced abortions since 1970 may have influenced the course of illegitimate live births. The increasing trend in the number of illegitimate live births and the illegitimacy rate, clearly visible from 1966 to 1970, subsequently dropped. The illegitimacy rate, which is calculated as a percentage of illegitimate live births of all live births, was 7.6 in 1966, 9.6 in 1970, and 9.0 in 1973. There was an absolute increase in the

[2] Statistics Canada, special tabulations for the Committee.

number of illegitimate live births by 4,583 from 1970 to 1973. For British Columbia, Ontario, and Alberta which had reported induced abortion rates which were consistently higher than the overall rate for the country, the reduction in illegitimacy rates after 1970 was clearly visible. For Newfoundland, Prince Edward Island, Nova Scotia, and New Brunswick with reported induced abortion rates which were lower than the national rate, the illegitimacy rates increased since 1970 for some of these provinces.

The number of infant and maternal deaths has declined substantially during recent years. In 1970 there were 75 pregnancy-related deaths of mothers, a number which decreased to 35 maternal deaths in 1974. Between 1970 and 1974 the decline in stillbirths was 24.0 percent (foetal deaths of 20 or more weeks of gestation); for infant deaths under one year of age by 20.2 percent; neonatal deaths (infants under 4 weeks) by 25.2 percent; and perinatal deaths (foetal deaths of 28 or more weeks of gestation plus infants under 7 days) by 23.4 percent. Maternal and infant death rates are sometimes used as barometers of the health status of a nation. But these measures lose their statistical significance, as in the case of Canada, when they reach relatively low levels. While it has sometimes been suggested that changes in these pregnancy-related death rates were due to one or another particular measure, it is a composite of factors which accounts for their reduction.

The reported increase in the number of induced abortions in Canada since 1970 coincided with and contributed to the broader demographic changes which were taking place in the composition of the Canadian population. For several decades there had been trends toward fewer births and smaller families, sharply reduced numbers of infant and maternal deaths, and since 1970, a reduction in the total number of illegitimate births.

The national crude birth rate has declined since 1960. Between 1970 and 1974, it dropped from 17.5 to 15.4 per 1,000 persons. The number of pregnancy-related deaths of women decreased from 75 in 1970 to 35 in 1974. The number of female sterilizations was 244,963 and the number of reported induced abortions was 124,129 between 1970 and 1973. The recent changes affecting induced abortions accelerated, but only partly contributed to the broader population trends.

Classification of abortions

Subsection 5(a) of Section 251 of the Criminal Code authorizes the provincial minister of health of the respective province to order therapeutic abortion committees of hospitals to supply him with copies of certificates which are issued "together with such other information relating to the circumstances surrounding the issue of that certificate as he may require." Under subsection 5(b) the minister can also require a medical practitioner who has performed the "miscarriage" or abortion to furnish "a copy of that certificate, together with such other information relating to the procuring of the miscarriage as he may require." There is no authorization in this legislation to make compulsory

the reporting of all therapeutic abortions nor for the establishment of a uniform national reporting and classification system for the coding of induced abortions. The legislation uses the terms "miscarriage", "therapeutic abortion", and "termination of pregnancy" interchangeably and as synonyms without direct definition.

While the legislation did not directly define an induced abortion, it stipulated that this procedure may be done in accredited or approved hospitals. An accredited hospital is one defined as "a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical, and obstetrical treatment are provided." One of the recommendations of the Canadian Council on Hospital Accreditation in its review for accreditation of hospitals is that "a recognized adaptation of the current revision of the *International Classification of Diseases,* which includes an operative classification, is recommended."[3] The 1955 edition of the *International Classification of Diseases,* published by the World Health Organization, was used in this country until 1969. This classification gave no definition of abortion. The revised edition of the manual published in 1968 defined abortion as follows: "Abortion (640-645): Includes any interruption of pregnancy before 28 weeks of gestation with a dead fetus."[4]

Prior to 1969 Statistics Canada coded the information on abortion which it received from the provinces based on the Seventh Revision of the *International Classification of Diseases.* This classification system then included three categories for the coding of abortions:

650—Abortion without mention of sepsis or toxemia

651—Abortion with sepsis

652—Abortion with toxemia without mention of sepsis.

Information on induced and spontaneous hospital abortions was provided for in the fourth digit of this international classification system. The hospital code for Operations and Non-Surgical Procedures which was used by the provinces until 1969 did not specify the causes of abortion. No distinctions were made between spontaneous abortions, induced abortions, or dilatation and curettage. For these reasons a review of trends by the various types of abortion over a period of time is precluded.

In 1969 the format for the classification of abortions in Canada was expanded when Statistics Canada adopted the Eighth Revision of the *International Classification of Diseases,* a coding system which had been adapted for use in hospitals by the United States Public Health Service. This system for the first time provided for the coding of induced abortions for medical, legal or illegal indications at the third digit level. It identified spontaneous abortion as a separate category. The association of sepsis or toxemia with abortion was

[3] Canadian Council on Hospital Accreditation, *Guide to Hospital Accreditation* (Toronto, 1972), p. 88.

[4] *Eighth Revision, International Classification of Diseases* (Washington, D.C.: United States Public Health Service, 1968), p. 298.

identified in the fourth digit. The categories for the classification of abortion which have been used since 1969 are:

640—Abortion induced for medical indications.

This category includes surgical abortion and therapeutic abortion and has subsections with or without sepsis or toxemia.

641—Abortion induced for other legal indications.

This section includes cases of rape, incest, and has subsections classifying sepsis and/or toxemia.

642—Abortion induced for other reasons.

This section includes criminal or self-induced abortion and has a subsection for sepsis, haemorrhage, or trauma to a pelvic organ.

643—Spontaneous abortion.

This category deals with abortion (complete) (incomplete) (with accidental haemorrhage of pregnancy).

Habitual abortion.

Diagnosis of miscarriage.

This section includes a fourth digit category with or without sepsis or toxemia.

644—Abortion not specified as induced or spontaneous.

In this section, cases are assigned where the diagnosis is of "abortion" without any further specifications. This section has subcategories of sepsis and/or toxemia.

645—Other abortion.

This category is a specialty section reserved for abortion associated with unusual medical conditions as carneous mole, placenta previa. This has septic and toxemia subsections.

When this more detailed means of classifying abortion was introduced and in combination with extensive information maintained on morbidity, personnel and facilities for hospitals operating under the federal-provincial hospital insurance program, the means were available to establish a detailed and continuous assessment of abortion trends. The information on hospitals maintained by Statistics Canada included: the age, sex, residence, and disease classification of patients; the size, location, and ownership of hospitals and their types of medical and surgical facilities; and the number and occupational categories of hospital personnel. These sources included information on hospitalized patients who had a primary diagnosis of abortion (induced and spontaneous) for all hospitals whether they had established or had not established therapeutic abortion committees. Out-patient services (patients who were treated on a day-care basis), as in the case of patients who were aborted yet who were not admitted to an overnight stay in hospital, were not included in these statistics. While limited in certain respects (e.g., the omission of out-patients), these sources of statistical information provided the potential to

outline in considerable detail the trends in abortions and their associated complications for the country or to focus on specific questions such as factors associated with the variable prevalence of spontaneous abortions, the volume and distribution of illegal abortions, or the provincial and rural-urban distribution of hospitals where abortions were done by the residence of patients. Until the time of this inquiry these sources of information had not been used to provide detailed reviews of these questions.

In addition to adopting the Eighth Revision of the *International Classification of Diseases* in 1969, a federal inter-departmental committee was established that year which represented the Department of Justice, the Department of National Health and Welfare, and Statistics Canada in order to undertake the development of a national therapeutic abortion statistics system. This step was initiated by the Department of Justice which in a request on June 26, 1969 to Statistics Canada stated:

> During the passage of the Criminal Law Amendment Bill (Bill C-150) through the House of Commons, the Minister gave an undertaking to follow the new abortion law in practice... It would be appreciated if you could obtain statistics relating to the number of therapeutic abortions performed in the approved and accredited hospitals in Canada under this proposed new provision.

Within the framework of the information collected by Statistics Canada, the decision was reached to make use of the statistics available from hospital in-patient records. The disadvantage of this system was that records from all provinces were not usually received until between 12 to 18 months after the year for which they were assembled. On August 1, 1969 a letter under the signature of the Dominion Statistician was sent to the heads of hospital services plans in the 10 provinces, Yukon and the Northwest Territories. The letter mentioned the requests by the Department of Justice for information, noted that the new legislation was expected to be proclaimed by about the middle of August and asked the provinces to make arrangements with hospitals with therapeutic abortion committees to submit information to the province to complete on a monthly basis a one-page form requesting the following information:

(1) Number of certificates for permission to perform a therapeutic abortion issued by therapeutic abortion committees in the province;

(2) Number of abortions performed on residents of the province;

(3) Number of abortions performed on residents of other provinces;

(4) Number of abortions performed on residents of other countries.

The response to this letter was not encouraging. Some provinces were slow to respond to the request. Where the collection of information was started, there was a widespread reluctance on the part of hospital administrators and individual doctors to provide the information. Officials in some hospitals feared the effects on the hospital of reporting the number of abortions which were being performed, or even of reporting that any were being done in the hospital. Individual doctors in some hospitals refused to cooperate in any abortion reporting program because of their dissatisfaction with the legislation.

During the 11 months from August 1969 to the end of June 1970 following the Dominion Statistician's letter of August 1, 1969, Statistics Canada sent additional letters and telex messages to provincial officials and telephoned or had personal contact with provincial and hospital officials. The results of this activity at the beginning of July 1970 were:

(1) Unwilling to supply any information—one province;

(2) No acknowledgement of communication—one province;

(3) Indicated willingness to supply statistics but none supplied—two provinces and two territories;

(4) Submitting information but incomplete information submitted—one province;

(5) Supplying statistics, perhaps complete but not verifiable by Statistics Canada—five provinces. One of the provinces had supplied information for March and April of 1970 only; four provinces supplied information for the months January to May 1970.

On the request of the Minister of Justice who was concerned about the inadequacy of the information which was being obtained, at a meeting on August 7, 1970 between the staff of the Department of Justice and Statistics Canada, it was agreed to undertake a "crash" program. The Department of Justice specifically requested that information be obtained on:

(1) The number of accredited hospitals with therapeutic abortion committees;

(2) The number of non-accredited but provincially approved hospitals with therapeutic abortion committees;

(3) The reasons why other hospitals had not set up committees;

(4) The number of applications made for therapeutic abortions;

(5) The number of applications approved and the number of applications rejected by therapeutic abortion committees;

(6) The number of deaths from illegal abortions, historically and for the most recent time period.

In conjunction with officials from the Department of Justice and the Department of National Health and Welfare, Statistics Canada designed a one-page form for completion by all hospitals with therapeutic abortion committees in Canada and on August 25, 1970 sent copies of the forms to the provinces. To meet the deadlines requested by the Department of Justice, the provinces were asked to attempt to have hospitals complete the form and submit it through provincial health authorities or directly to Statistics Canada by September 11, 1970. By September 14, 1970 the receipt of the letter of August 25 (sent under the signature of the Dominion Statistician, registered, special delivery, and airmail) had not been acknowledged by seven of the provinces, the Yukon and Northwest Territories. Two provinces had acknowledged receipt of the letter and had promised to have the forms completed. One province had submitted forms but the forms contained omissions or peculiarities which made it impossible to prepare all the proposed tables. Although the response by the hospitals was slower than the timetable required to enable

Statistics Canada to meet the deadlines requested by the Department of Justice, all hospitals in Canada with therapeutic abortion committees, except for 2 or 3 hospitals in Ontario and Quebec, had submitted reports. Based on information from this special survey, Statistics Canada issued its first report on therapeutic abortions in Canada on November 20, 1970.

Early in 1971 the interdepartmental committee recommended the setting up of a more detailed reporting system than the existing "crash" program format on therapeutic abortions. Requiring the approval and participation of provincial health authorities, the committee recommended that an individual case register for therapeutic abortion patients be established. The information which it was agreed would be collected for each patient who had had an abortion approved by a hospital therapeutic abortion committee included:

I. General Items

1. Hospital identification—name and address;
2. Case identification—hospitalization number or hospital case number;
3. Province of report;
4. Province of residence of the patient.

II. Demographic Items Concerning the Patient

5. Age;
6. Marital status;
7. Previous deliveries;
8. Previous abortions—spontaneous and induced;
9. Date of last normal menses;
10. Date foetus expelled.

III. Medical Items Concerning the Patient

11. Surgical procedure(s) used;
12. Concurrent sterilization and procedure used;
13. Abortion complication(s), if any;
14. Days of hospitalization;
15. Indication—medical, psychiatric, or social.

All participating hospitals were asked to complete the General and Demographic Items (1-9) and the days of hospitalization (14). The completion of the five Medical Items (10-12, 13, 15) was requested on an optional basis. During the autumn of 1971, this format was pre-tested in Manitoba, Saskatchewan and Alberta with the revised program submitted for review to all of the provinces in November 1971. The use of the individual case register started in one territory and six provinces in January 1972. By May 1974, all areas in the country were participating in this information collection system. It was not until that date that full information for the whole country was obtained on patients who had therapeutic abortions.

Areas Included	Date Started	Therapeutic Abortions Reported in Individual Case Register
		(%)
Alberta, Manitoba, New Brunswick, Newfoundland, Prince Edward Island, Saskatchewan, Yukon	January 1, 1972	17
Nova Scotia, Quebec	January 1, 1973	26
British Columbia, Northwest Territories	January 1, 1974	49
Ontario	April 1, 1974	86
All areas	January 1, 1975	100

The information provided by participating hospitals was routed through provincial health departments (three provinces and two territories) or sent directly (seven provinces) for tabulation to Statistics Canada. Providing a more extensive baseline of items on therapeutic abortion than had previously existed, the individual case register included information which permitted the analysis of: the length of gestation up to 28 weeks of induced abortion patients by other patient attributes; the types of procedure done by hospital attributes; post-operative complications related to the age, parity, and duration of pregnancy of patients; the identification of regions (provincial, rural-urban) and of categories of hospitals with unusual proportions of second and third-trimester abortion patients; health risk factors for young (under age 15) and older (above age 40) patients; the distribution of abortions comparing the location of hospitals where these procedures were done by the residence of patients on a local, regional, and provincial basis; the effects of abortion trends on fertility relating to the composition and growth of the Canadian population; and the attributes of hospitals with and without therapeutic abortion committees on the volume of type of abortion, and for hospitals with committees, factors related to the volume of induced abortions which were done.

Provincial medical care insurance commissions maintain information on the procedures paid for under existing fee payment schedules for physicians. Because there are sizeable variations between the provinces in how procedures are classified for payment, and in particular, how these relate to induced abortion, no uniform summary from these sources can be made for the country. Within the context of the categories used in a particular provincial fee schedule, and when combined with provincial hospital insurance sources, the following types of information have been compiled by some provincial medical care insurance sources: (1) age; (2) sex; (3) marital status; (4) place of residence; (5) the procedure paid for; (6) the location of hospitals; (7) the range of hospital facilities; (8) the cost of procedures; (9) the number of physicians doing specific procedures; and (10) the volume of procedures done by each medical specialty. Since 1970, four of the ten provinces have undertaken special reviews of abortion. These studies have been done by: Alberta (1975), Manitoba (1973), Ontario (1972), and Quebec (1974). One report on

abortion trends was published by Quebec, *Dossier sur l'avortement* (Conseil des Affaires Sociales et de la Famille, 1974).

Each provincial health authority and the federal Department of National Health and Welfare were asked about the means which they used to classify all categories of abortion, whether there had been any changes in these systems since 1969, and if they had any special problems involved in the classification of abortions. No problems in the classification of all categories of abortions were reported by six provinces. In Ontario the full four digit classification of the *International Classification of Diseases* was adopted in 1971. This classification provides for the listing of "abortions induced for other legal indications". This category of induced abortions is reported, although it is recognized that "medical indications are the only legal reasons for abortion in Canada". A separate classification is maintained in Ontario for the reporting of "medical indications".

In Manitoba, complications associated with therapeutic abortions are coded separately. Incomplete abortions (dilatation and curettage) are generally classified under code 643 (spontaneous) of the *International Classification of Diseases* in Alberta, while abortions induced by the saline procedure which are followed by a dilatation and curettage are classified under code 640. Abortions whose indications are not specified are listed under code 645. A dilemma in coding induced abortions according to the *International Classification of Diseases* used by Statistics Canada is that, as in the instance of Alberta, an intermediate step is required to derive this code which is based on the classification of the provincial medical fee schedule. As new procedures involved in the termination of pregnancies have been used, in British Columbia these procedures, such as intra-amniotic injection of urea, aspiration curettage or the laminaria tent have been subsumed within the existing codes of the *International Classification of Diseases.*

In its classification of medical care insurance statistics, the federal Department of National Health and Welfare relies upon provincial reports which classify abortions according to provincial fee code schedules. These systems of classification do not specify the types of abortions, but indicate the nature of the medical procedures which have been used. The Department of National Health and Welfare indicated there was a problem of comparability involved in the continued use of two different classification systems at the national level—the use of the *International Classification of Diseases* by Statistics Canada and the federal health department's use of the reporting system based on prescribed provincial medical fee code schedules. The federal health authority recognized that code 644, "abortion not specified as induced or spontaneous", of the *International Classification of Diseases* was a "catch-all" category, one which "may be used for abortions other than those induced directly for 'therapeutic' purposes".

Since the enactment of the abortion legislation in 1969, extensive sources of information have become available to federal and provincial health authorities and Statistics Canada. Three main sources on abortion statistics (hospitalization information; individual case register maintained by Statistics Canada; and provincial hospital and medical care insurance sources) were drawn upon

by the Committee in meeting some of its Terms of Reference. Because of changes in the means of classification, the variable range of items which were included in a particular source, and differences in the definitions of specific abortion procedures, trends for all categories of abortions cannot be analyzed with consistency and continuity. In each instance where these sources are used in the Committee's Report, the findings are interpreted within the context of how the information was obtained.

Two different systems are used in the classification of induced and other types of abortions at the national level. These systems lead to much confusion and inaccuracy in the classification of all categories of abortions.

The discrepancy is great between the actual and the potential use of existing sources of information about all types of abortion and their associated health complications.

Reasons other than a lack of information account for the paucity of resources allocated by government to the investigation of abortion or the full study of the questions which were initially put by the Minister of Justice on August 7, 1970. In these respects there is a need for more sunshine about information collected in the public interest. The fact that there has been little analysis of available sources is a measure of the sense of trepidation with which induced abortion has been seen and of the fragile accord which involves patients, physicians, hospitals, and federal and provincial authorities in the collection of abortion information.

Indices and trends: 1961-1974

The number of reported therapeutic abortions obtained by Canadian women over a period of years can be considered by itself, or compared with other factors involved in the composition and growth of the population. If the first approach is taken, then there was an absolute increase of 332 percent between 1970 and 1974. This change, which is substantial, gives little indication of other factors which may be related to the increase. Several means of comparison can be used to describe the number of therapeutic abortions done in Canadian hospitals. While all of these comparative measures show there has been an increase during this period, the size of the change varies with the index which is being used. The baseline indicators most often used in studies of births, maternal deaths, and abortions are: (1) total population; (2) women between the ages of 15 and 44 years;[5] (3) live births; and (4) live births and abortions.

The dilemma involved in using these several indicators of population growth, or in basing conclusions on only one measure, revolves around the definitions and the assumptions upon which they are based. In this context the equation of an increasing abortion rate with a declining birth rate poses a

[5] Depending upon the source of information from Statistics Canada, the age range varies between 10 and 54 years.

double-blind situation. Abortions function to lower a birth rate. Sterilization—a permanent means of contraception—by reducing the number of fertile women in the reproductive years serves to raise the birth rate among women who are capable of childbirth. Likewise, the comparison of live births and abortions with a total population composed of men and women provides no indication of the distribution by sex for that population which may have a balanced distribution, or as is the case with some communities in Canada, may have more men than women. If women in the childbearing years are taken as a denominator with which live births or abortions are compared, then the assumption is made that all women between 15 and 44 years are capable of reproduction. That this is not the case in Canada is evident from the 257,795 women who were sterilized between 1969 and 1973, which reduced the number of women in the reproductive years by 5.3 percent and on this basis revises upward both the birth rate and the reported abortion rate if this denominator is used. For these reasons no single measure by itself is sufficient to account for changes either in the birth rate or the abortion rate. The assumptions upon which these standards are based, some of which have been used for a long time in international studies, are no longer completely valid. A fresh look is called for to develop a composite index of the components of population growth which accounts for the number of women in the reproductive years, the number of live births, neonatal and perinatal deaths, the extent of sterility and sterilization, and the impact of various categories of abortion.

Prior to 1960 there was no accurate or uniform assessment of the number of abortions done in Canadian hospitals. This change came about as a byproduct of national hospital insurance. At the time Statistics Canada was given the authority to collect information on hospital morbidity and facilities. Prior to 1969 when the Eighth Revision of the *International Classification of Diseases* was introduced, there was no means of accurately identifying the several categories of abortion. Full information for Quebec and Alberta was not available for 1960. The records maintained by Statistics Canada listed all categories of abortions which were done in hospitals on an in-patient basis. No estimates are available for the 1960-1969 period of the number of induced abortions which may have been done on an out-patient basis. The shifts which have been published in how many abortions have been obtained relate directly to trends in all categories of reported abortions. With this in mind, only rough measures are used which relate the number of abortions in all categories per 1,000 individuals in the total population and to the number of women between the ages of 10 and 54 years. This age category is taken for there is no age-specific information for women who had abortions in the 1960s.

The rate of all abortions to the total population of 4.8 per 1,000 in 1961 was the highest rate reported between 1961 and 1974. That was the first year after the introduction of national hospital insurance for which there was a complete listing of abortions done in hospital. During the rest of the 1960s, this rate dropped, reaching 2.1 per 1,000 in 1969. At the start of the 1970s the rate rose again. By 1973 it had increased by 81.0 percent over the rate for 1969, but it was 20.8 percent lower than the highest rate which was recorded in 1961.

The rate of increase of reported induced abortions was greatest between 1970 and 1971, when there was a change of 177.3 percent. In succeeding years,

based on this measure, there was a sharp curtailment in the pace of annual growth, which was 11.4 percent between 1973 and 1974. Each of the other four measures used to analyze abortion trends shows comparable trends—a high rate of increase between 1970 and 1971 and a declining rate of change in recent years. When the number of abortions is compared with the size of the Canadian population, the rate was 2.1 abortions per 1,000 individuals in 1974. While this rate had risen substantially from the 1970 rate of 0.5 per 1,000, between 1973 and 1974 it rose by 4.8 percent. **In 1974, 10 out of every 1,000 women (9.5 per 1,000) between the ages of 15 and 44 years had a reported induced abortion in a Canadian hospital. For every 100 live births there were 13.9 induced abortions.** What these measures involve is a comparison of two shifting trends as in the case of the increase in the number of abortions with a declining birth rate.

TABLE 4.1

THERAPEUTIC ABORTIONS PER 1,000 FEMALES 15-44 YEARS AND THERAPEUTIC ABORTIONS PER 100 LIVE BIRTHS: BY PROVINCE, 1970-1974*

STATISTICS CANADA

Province	Therapeutic Abortions per 1,000 females 15-44 years					Therapeutic Abortions per 100 live births				
	1970	1971	1972	1973	1974	1970	1971	1972	1973	1974
All areas	2.4	6.4	7.9	8.6	9.5	3.0	8.6	11.2	12.6	13.9
Stratum I										
British Columbia	6.4	15.0	16.7	17.8	19.0	7.9	20.2	23.7	26.7	28.3
Yukon	1.6	2.0	10.9	17.3	14.6	1.3	1.6	10.6	18.1	12.7
Ontario	3.3	9.4	11.5	12.5	13.7	4.1	12.4	16.2	18.3	20.0
Alberta	3.3	8.6	10.2	10.7	11.4	3.6	10.2	13.3	13.8	14.7
Northwest Territories	—	—	5.6	6.1	9.4	—	—	3.6	4.2	7.2
Stratum II										
Nova Scotia	1.6	3.9	5.0	5.3	6.1	1.8	4.5	6.2	7.0	8.2
Manitoba	1.2	4.0	5.6	5.9	6.6	1.3	4.6	6.8	7.4	8.2
Saskatchewan	1.1	4.1	5.7	6.6	6.5	1.3	4.7	6.7	8.2	7.8
Stratum III										
Prince Edward Island	0.8	1.8	2.0	1.7	2.1	0.9	1.9	2.2	2.2	2.6
New Brunswick	0.5	1.1	1.3	2.4	3.1	0.6	1.2	1.6	3.0	3.8
Quebec	0.4	1.3	2.0	2.2	3.1	0.6	2.1	3.4	3.7	5.2
Newfoundland	0.2	0.7	1.1	1.6	1.6	0.2	0.6	1.0	1.6	1.8

* Rates per 1,000 females 15-44 years of age for 1970 and 1971 and for some areas for 1972 to 1974 were based on the estimated number of induced abortions in the age group.

Two measures, the number of women between the ages of 15 and 44 years and the number of live births, show substantial differences in the distribution of induced abortion rates between the provinces. The induced abortion rates for British Columbia, Ontario, and Alberta for the five-year period, based on the number of females between 15 and 44 years of age and the number of live

births, were between one and one quarter times to two and one half times higher than the rates for all areas. These provinces contributed more than 80 percent of the total induced abortions for Canadian residents for each year between 1970 and 1974. The abortion rates for Nova Scotia, Manitoba, and Saskatchewan ranged approximately from one-third to slightly more than half of the abortion rates for all areas. The abortion rates for Newfoundland, Prince Edward Island, New Brunswick and Quebec were less than one-third of the abortion rates for all areas.

The U-shaped distribution of all categories of induced abortions from 1961 to 1974, high-low-high, was influenced by three related trends which involved the reporting of abortions by government sources. These factors were: (1) the definitions used in the classification of abortions; (2) the number of illegal abortions obtained by Canadian women; and (3) the number of Canadian women obtaining abortions in the United States.

Induced, spontaneous, and other abortions

Prior to 1969 there was no statistical breakdown for the country of the reported number of spontaneous and therapeutic abortions. The total number of reported abortions (induced in hospital; induced on an out-patient basis; spontaneous; and other categories) rose from 77,228 in 1971 to 84,106 in 1973. When these abortions are considered as a proportion of the number of live births, induced abortions rose from 8.6 to 12.6 percent; spontaneous abortions from 1.4 to 1.7 percent; and other abortions dropped from 9.2 to 8.5 percent. Almost half of all reported abortions in Canada in 1971 (49.7 percent) were induced; 6.5 percent were spontaneous; and other abortions accounted for 43.8 percent. This distribution shifted by 1973 to include 57.3 percent induced abortions; 7.1 percent spontaneous abortions; and 35.6 percent other abortions. In absolute numbers, abortions classified as "other" declined from 33,275 to 29,938 between 1971 and 1973.

In the Eighth Revision of the *International Classification of Diseases* the coding categories of 640-641 are used to list therapeutic abortions; category 642 includes abortions induced for other reasons such as criminal or self-induced; category 643 is used to list spontaneous abortions or miscarriages; and categories 644-645 constitute a catch-all classification for abortions not specified as induced or spontaneous. Categories 640 and 641 listing induced abortions for medical or other legal reasons are the codes used to list officially reported therapeutic abortions, i.e., those induced abortions which have been performed after approval has been given by a hospital therapeutic abortion committee. By definition, abortions which are not considered or listed in these two coding categories do not require the approval of such a committee. Abortions in categories 643-645 constituted 42.7 percent of reported abortions in 1973.

Category 642, "other induced abortions", does not involve a review of patients by a hospital therapeutic abortion committee. Patients classified under

this code dropped from 87 in 1969 to 65 in 1973. The number of spontaneous abortions, or those occurring naturally for physical and genetic reasons, are regarded as invariate or unchanging. Although estimates vary, after a woman has missed her first period it is generally estimated that among women living in western countries the spontaneous abortion rate is about 15 percent. It has been found in some studies that the spontaneous abortion rate varies by a woman's age with older women having higher rates than women in their early twenties. The rate for reported spontaneous abortions remained relatively constant in Canada between 1971 and 1973.

Categories 644 and 645 are the two final categories used for the classification of abortion. The full listing for category 644 is:

644—Abortion not specified as induced or spontaneous.

Includes: abortion (complete; incomplete; with accidental haemorrhage of pregnancy), not specified as induced or spontaneous.

The listing for category 645 is:

645—Other abortion

Includes: carneous mole
fleshy mole
haemorrhagic mole
molar pregnancy
} not specified as undelivered
placental polyp with abortion
retained products of conception

Abortions not specified as induced or spontaneous (category 644) accounted for 113,533 reported abortions between 1970 and 1973, a number almost equal (91.5 percent) to the 124,129 reported therapeutic abortions done in Canadian hospitals for the same period.

TABLE 4.2

ABORTION RATES PER 1000 POPULATION, 1973

STATISTICS CANADA

Province	Classification of Abortions*			
	Induced	Spontaneous	Other	Total
Newfoundland	0.4	0.13	2.1	2.6
Prince Edward Island	0.4	0.03	1.8	2.2
Nova Scotia	1.2	0.06	1.3	2.6
New Brunswick	0.5	0.05	1.5	2.1
Quebec	0.5	0.24	1.3	2.0
Ontario	2.8	0.05	1.6	4.5
Manitoba	1.3	0.37	1.3	3.0
Saskatchewan	1.3	0.12	1.3	2.7
Alberta	2.4	1.73	2.4	6.5
British Columbia	4.0	0.24	4.0	8.2
TOTAL	2.0	0.27	1.3	3.6

* Based on codes 640,641 (induced), 643 (spontaneous) and 644 (other) of the *International Classification of Diseases.*

The ratio of induced abortions was three times higher for Nova Scotia than Newfoundland and Prince Edward Island, while the rate in British Columbia was 10 times higher than for Newfoundland and Prince Edward Island. **Provinces with lower rates for induced abortions had substantially higher rates for spontaneous abortions and other abortions** (Code 644). The rate for spontaneous abortions in Quebec was five times higher than its two neighbouring provinces of New Brunswick and Ontario, while the rate for Alberta of 1.73 spontaneous abortions per 1,000 live births was 35 times higher than the 0.05 rate for New Brunswick. With the exception of Nova Scotia, the eastern provinces of Newfoundland, Prince Edward Island, New Brunswick, and Quebec had lower rates of induced abortions than other abortions (Code 644) in 1973. The rate of induced abortions in Ontario was higher than for other abortions, and this ratio between induced and other abortions was balanced for the four western provinces.

The rate of spontaneous abortions, those abortions classified as resulting from physical or genetic causes, was 17.4 per 1,000 *live births* for Canada in 1973. The rate of spontaneous abortions varied substantially between the provinces, with low rates occurring in Prince Edward Island (1.6), New Brunswick (3.1), Ontario (3.4), and Nova Scotia (3.8); intermediate rates in Newfoundland (5.7) and Saskatchewan (7.6); and high rates in British Columbia (16.0), Quebec (17.1), Manitoba (21.8), and Alberta (99.7).

In terms of their rank order from low (1) to high (10), the rates by province for induced, spontaneous, and other (code 644) abortions per 1,000 *live births* in 1973 was:

	Induced Abortions	Spontaneous Abortions	Other Abortions
Newfoundland	1	5	7
Ontario	2	3	9
Prince Edward Island	3	1	10
New Brunswick	4	2	5
Quebec	5	8	6
Nova Scotia	6	4	3
Manitoba	7	9	2
Saskatchewan	8	6	8
Alberta	9	10	1
British Columbia	10	7	4

In addition to an absolute decrease between 1969 and 1973 in the number of "other" abortions (code 644), the distribution of abortions in this category varied considerably between the provinces. Similar substantial differences occurred among the provinces in the reported rates for spontaneous abortions. There has been no detailed study of the medical reasons of the diagnoses associated with the sizeable number of abortions listed in the "catch-all" categories of 644 and 645 in the *International Classification of Diseases.* While the trend was not uniform for all provinces, and varied somewhat with the comparative baseline which was used, provinces which had lower rates of induced abortions in 1973 had proportionately higher rates of "other" abor-

tions. In contrast, in those provinces which had higher rates of therapeutic abortions, these rates were of the same order for "other" abortions.

While it is usually assumed that within defined proportions the prevalence of spontaneous abortions is relatively invariate, this was not the case in the rates of reported spontaneous abortions among the provinces. In reviewing the classification of all categories of abortions and the trends for induced abortions with the senior medical staff of the 140 hospitals visited by the Committee, while there was no consensus on these issues, the explanations most frequently advanced to account for the variation in abortion rates involved the impact of induced abortions in lowering the rate of spontaneous abortions and the nature of variable medical customs used in the classification of abortions. A number of heads of hospital departments of obstetrics-gynaecology concluded that trends and differences in the rates of spontaneous abortion were accounted for by an improved standard of living, more extensive maternal care, the use of more effective drugs, and because the rate of induced abortions had risen, a number of women, because of their lower parity and the more extensive use of contraception who otherwise might have spontaneously aborted had instead had therapeutic abortions.

TABLE 4.3

ABORTIONS PER 1000 LIVE BIRTHS, 1973

STATISTICS CANADA

Province	Classification of Abortions*			
	Induced	Spontaneous	Other	Total
Newfoundland	16.2	5.7	95.2	117.1
Prince Edward Island	21.7	1.6	108.7	132.0
Nova Scotia	70.1	3.8	79.2	153.1
New Brunswick	29.8	3.1	83.2	116.1
Quebec	37.4	17.1	90.6	145.1
Ontario	18.3	3.4	99.7	121.4
Manitoba	74.2	21.8	67.9	163.9
Saskatchewan	82.3	7.6	97.1	187.0
Alberta	138.2	99.7	8.8	246.7
British Columbia	267.1	16.0	80.7	363.8
TOTAL	125.4	17.4	84.3	227.1

*Based on codes 640, 641 (induced), 643 (spontaneous), and 644 (other) of the *International Classification of Diseases.*

While plausible, these reasons do not fully account for the fact that Alberta and British Columbia, both of which had high rates of therapeutic abortions in 1973, also had high rates of spontaneous abortions (99.7 and 16.0 per 1,000 respectively in 1973), or for the sharp inter-provincial differences in the rates for spontaneous abortions. An alternate explanation put forward by some obstetrician-gynaecologists was that variations in the rates listed for therapeutic abortions, spontaneous abortions, and other abortions (code 644)

resulted from how these operations were classified. According to this perspective, what might be classified after a review by a hospital committee as a therapeutic abortion in one hospital could be listed either as a spontaneous abortion or "other" abortion (code 644) in hospitals without committees. The extent to which social and professional factors might influence the definition and the classification of spontaneous and other abortions was reviewed on the basis of information obtained by the survey of hospitals undertaken by the Committee.

In the survey of general hospitals, information was requested on 1975 vital statistics relating to stillbirths, maternal deaths, and spontaneous abortions. Information was incomplete for a number of hospitals which used central statistical compilation sources. Representing 195,317 reported live births for 1975, or 56.5 percent of 1974 live births,[6] the experience of 404 general hospitals was considered in terms of the number of reported spontaneous abortions relative to the number of reported live births. In listing this information for the Committee, hospitals included information on spontaneous abortions (code 643) and abortions not specified as induced or spontaneous (code 644). The rate of these reported non-induced abortions per 1,000 live births by the size of hospitals is given in Table 4.4 for: (1) hospitals with therapeutic abortion committees; (2) lay hospitals (voluntary associations, municipal, provincial, or federal) without committees; and (3) religious hospitals (owned by or affiliated with a religious denomination) without therapeutic abortion committees.

On the basis of the usually accepted definition of spontaneous abortion and the fact that abortion not specified as induced or spontaneous (code 644) is a residual category, a relatively uniform distribution of abortions in these categories might be expected among all general hospitals. This was not the case. **The rates of spontaneous and other abortions (codes 643 and 644) varied substantially by: (1) the size of hospitals; (2) whether hospitals had established or not established therapeutic abortion committees; and (3) the type of ownership of hospitals without committees.**

For the 404 hospitals in which 195,317 live births were reported for 1975, the ratio of spontaneous and other non-induced or spontaneous abortions was 78.2 per 1,000, or in terms of percentages, were 7.8 percent of live births. Small (under 99 beds) and intermediate size (200-299 beds) hospitals had the highest ratios, followed by hospitals with 100-199 beds. The largest hospitals, those with more than 300 beds where a majority of the live births occurred (58.0 percent) had a ratio of 72.7 per 1,000 or 18.2 percent lower than small hospitals under 99 beds which had 11.8 percent of the live births.

For the 161 hospitals with therapeutic abortion committees which provided full information, the ratio of spontaneous and other abortions (77.0 per 1,000 live births) was comparable to the ratio (78.2) for all hospitals. For the hospitals with committees, there was an inverse distribution of spontaneous and other abortions by the size of the hospital. The ratio for small

[6] The total 1975 live births were unknown for the country at the time of the survey.

hospitals was 96.4 per 1,000 live births, a ratio which was 26.4 percent higher than the ratio of 71.0 per 1,000 of hospitals with over 300 beds. For those hospitals without committees which were owned by community associations, municipalities, and provincial and federal governments, the overall ratio of these categories of abortions of 87.9 per 1,000 live births, was 11.1 percent higher than for all hospitals. With the exception of hospitals with over 300 beds, there was a direct relation between the size of a hospital and the ratio of spontaneous and other abortions per 1,000 live births. This ratio rose from 82.8 per 1,000 for small hospitals (under 99 beds) to 119.9 per 1,000 for intermediate hospitals (with 200 to 299 beds). This ratio of 119.9 per 1,000 live births was 34.8 percent higher than the ratio for all hospitals (78.2 per 1,000).

TABLE 4.4

SPONTANEOUS AND OTHER ABORTIONS PER 1,000 LIVE BIRTHS IN COMMITTEE AND NON-COMMITTEE HOSPITALS: BY SIZE AND OWNERSHIP OF HOSPITALS, 1975*

NATIONAL HOSPITAL SURVEY

Size of Hospital	Spontaneous and Other Abortions per 1,000 live births			Total
	Hospitals With Committees	Lay Hospitals Without Committees	Religious Hospitals Without Committees	
Under 99 Beds	96.4	82.8	85.7	88.8
100-199 Beds	84.0	90.7	65.3	82.1
200-299 Beds	85.8	119.9	81.8	88.4
300 Beds and above	71.0	85.2	68.4	72.7
Average	77.0	87.9	70.7	78.2

*Codes 643 and 644, *International Classification of Diseases.*

The experience of religious hospitals without committees was different from hospitals with committees and non-religious hospitals without committees. These hospitals had the lowest ratio (70.7) of spontaneous and other abortions per 1,000 live births. Small and intermediate-sized religious hospitals had higher ratios, followed by large hospitals (over 300 beds) and hospitals with 100 to 199 beds. In comparison with non-religious hospitals without committees, the ratio of spontaneous and other abortions per 1,000 live births of religious hospitals was 19.7 percent lower.

Like the uneven 1973 provincial distribution of therapeutic, spontaneous and other abortions, this information on the committee status and ownership of hospitals revealed marked differences involving their experience with spontaneous and other abortions. **Religious hospitals, most of which on stated moral**

principles were opposed to induced therapeutic abortion, had the lowest ratio per 1,000 live births of spontaneous and other abortions.

In the judgment of the Committee, this ratio for religious hospitals represents a more accurate estimate of abortions which result from natural and biological causes. Hospitals with therapeutic abortion committees had a higher ratio than religious hospitals, but one which was considerably lower than for non-religious hospitals without committees. For hospitals with therapeutic abortion committees, the option was available to classify abortions as therapeutic (codes 640-641). For whatever reasons, this option was not available to non-religious hospitals without committees. Their experience with considerably higher ratios of spontaneous and other abortions may represent differences in: (1) the attributes of patients seeking care at these hospitals; (2) the quality of care which was provided; or (3) the definitions used to classify abortions. From the site visits made by the Committee to 140 hospitals, there was no indication of marked differences in the age, marital status, or social circumstances of patients seeking care along these lines. All of the hospitals in the Committee's survey were approved by provincial health authorities and a considerable number in each category (with and without committees) were accredited. The substantial differences in the rates for spontaneous and other abortions resulted from the different definitions which were used in the classification of abortions.

Illegal abortions

For the purposes of this inquiry legal abortions were defined as abortions done after approval had been given by a duly constituted hospital therapeutic abortion committee in an approved or an accredited hospital in Canada, as well as those spontaneous abortions and "other" abortions designated in the *International Classification of Diseases*, codes 644-645. Illegal abortions were defined as those induced abortions which were not so classified which were done in Canada: (1) in hospitals without committees; (2) in physicians offices; (3) by laymen; and (4) were self-induced. Induced abortions obtained by Canadian women outside the country were not defined as being illegal, as under Section 5(2) of the Criminal Code, "Subject to this Act or any other Act of the Parliament of Canada, no person shall be convicted in Canada for an offence committed outside of Canada".[7]

Knowledge of the Law. A substantial number of patients who had induced abortions as well as many physicians, nurses and people across Canada did not know the terms of the Abortion Law. A large number of individuals in each group who were surveyed by the Committee either said that obtaining an abortion was illegal in Canada, attributed to the law terms which it did not have, or did not know what the statute involved. Despite this lack of knowledge about the law, the Committee found that many individuals—patients, doctors,

[7] *Criminal Code* Revised Statutes of Canada 1970, C. c-34, s.5.

nurses and the public—held strong views on the issue of abortion and on what they imputed to be the terms set out in the law.

The Abortion Law does not directly stipulate the length of time in weeks for a pregnancy concerning the abortion procedure. In requiring that this operation must be done either in an accredited or an approved hospital, the requirement of the Canadian Council on Hospital Accreditation is involved concerning the use of the *International Classification of Diseases*, a codification system which defines abortion as "any interruption of pregnancy before 28 weeks of gestation with a dead fetus".[8] In the survey of all obstetrician-gynaecologists in Canada and a 25 percent sample of family doctors, these physicians were asked: "What is your understanding of the length of gestation set for a therapeutic abortion in the Abortion Law?" The results indicated that a majority of doctors believed that the law sets a specific time requirement in terms of the number of weeks when the abortion procedure can be done.

More family doctors (55.0 percent) than obstetrician-gynaecologists (22.4 percent) reported that the length of gestation was under 16 weeks. A third of the family doctors (30.5 percent) and two thirds (63.6 percent) of obstetrician-gynaecologists set the upper limit at 20 weeks. An almost equal number of both groups of physicians gave the length of time as above 20 weeks. Less than 1 percent of family doctors and obstetrician-gynaecologists stated that the Abortion Law set no time limits within which it was legal to do this procedure. These opinions of physicians have direct implications in terms of the guidelines set for the length of gestation by hospital therapeutic abortion committees and how doctors, in particular family physicians who were the source of primary contact by patients, counselled women seeking an abortion. About 3 out of 4 nurses in the hospital personnel survey (76.0 percent) done by the Committee said they knew the terms of the Abortion Law, but 34.1 percent set 12 weeks as the legal limit for induced abortions, 13.6 percent cited 16 weeks and 16.7 percent 20 weeks.

Knowledge of the law was obtained by the Committee from two groups of patients, a small number who had abortions in the United States and from 4,754 patients who had abortions in Canadian hospitals in 1976. A fifth of the patients who went to the United States (22.6 percent) said they had been told by a physician that getting an abortion in Canada was illegal. The patients who obtained abortions in 1976 in Canadian hospitals were asked: "Would you tell us what rules and laws are used to decide if a woman can have an abortion?" Half of these patients knew nothing about the law (50.5 percent) and a few (2.0 percent) felt abortions were illegal. Among the women who were carrying their pregnancies to term and who were assisted by welfare agencies or living in maternity homes, 2 out of 5 (40.0 percent) said that obtaining an induced abortion was illegal in Canada.

The findings from these surveys indicate that **there is a widespread lack of knowledge about the Abortion Law. Its specific terms are often misunderstood.** There has been some considerable public discussion about the law. A

[8] Eighth Revision *International Classification of Diseases*, Washington: United States Public Health Service, 1968, p. 298.

number of widely quoted surveys and polls have been done. In the light of the information obtained by the Committee, it is not clear what some of these previous findings may represent, for it has been usually assumed that people whose opinions were recorded knew what they were talking about in terms of the actual sections of the Abortion Law. The Committee did not accept these assumptions about an *a priori* knowledge of the Abortion Law. In seeking information from patients in Canada and the United States, physicians, and in the national population survey, each group was asked either if obtaining an abortion was legal or illegal in Canada or about their knowledge of the specific terms of the law. A number of other questions seeking opinions about whether individuals felt the law was too liberal or too restrictive or the conditions under which they felt induced abortions should be obtained were also asked. But these questions, like those used in other investigations, must be seen in the context of whether in fact people know what the law is about abortion. This was decisively not the case for the individuals from whom information was obtained by the Committee.

Although the terms of the Abortion Law went into effect on August 26, 1969, over six years later in 1976 a majority of physicians who were surveyed did not know its terms relating to the length of gestation, approximately half of the patients who had abortions did not know about the law, and only one third of the individuals in the national population survey said that getting an induced abortion was legal in Canada. Lack of knowledge or inaccurate knowledge about the law poses a major dilemma in how its procedures operated in practice. This lack of information contributed in part to different standards which were used by hospitals and physicians involved in the abortion procedure and accounted for the fact of some patients leaving the country to obtain abortions. For some abortion referral agencies in Canada and a large number of abortion centres in American states adjacent to the Canadian border, it served well their financial and practice interests to maintain a mystique about the issue and to reinforce the myth that induced abortion under any circumstances was illegal in Canada.

Charges and Convictions. It is estimated that a sizeable number of Canadian women in recent decades obtained illegal abortions. While their exact number is unknown, many women attempted or succeeded in self-induction. Most of the illegal abortions were procured from laymen, itinerant quacks, and licensed or unlicensed physicians. The "tracer" effects of illegal abortions were visible in the form of an extensive number of medical complications (sepsis, perforated uterus) or to a lesser extent maternal deaths associated with abortions. Although information for Ontario is missing, the number of operations for abortion with sepsis across Canada rose from 849 in 1961 to 1,608 in 1966, or almost doubled during this period. The number of such cases dropped to 1,302 in 1969, 1,173 in 1970, 1,239 in 1972, to 907 in 1973. Between 1962 and 1966, abortion became the leading cause of maternal deaths in Ontario, accounting for 19.7 percent of these deaths of women. **The number of deaths of women for Canada resulting from attempted self-induced or criminal abortions, which averaged 12.3 each year between 1958 and 1969, dropped to 1.8 deaths annually from 1970 to 1974. In 1970 there were five**

maternal deaths due to illegal abortion in Canada, one in 1971, one in 1972, none in 1973, and two in 1974.

While self-induction and the involvement of illegal sources to terminate a pregnancy were criminal offences, virtually no charges through the years were laid against the women who sought an abortion. Such women were regarded as the victims of unfortunate circumstances. The force of the law was brought against illegal abortionists. During the 1950s and 1960s almost every major city in the country had laymen or physicians who were known to do abortions, and to whom patients were referred. These cities included Halifax, Moncton, Montreal, Toronto, Hamilton, Winnipeg, Calgary, Edmonton, and Vancouver, as well as smaller centres such as Waterford, Blind River, Sturgeon Falls, Olds, and Lacombe. The nature of this practice which was said to have occurred was given by two physicians.

> I am no longer in practice. My colleagues in medicine shunned me, although 90 percent of the women who came to me had been referred by physicians from as far away as Nome, Hawaii, New York, Montreal, Miami and points in between.
>
> I will not tell you how many abortions I procured, but I will say that I never lost a woman. The incidence of morbidity was nil. All operations were performed in my office under rigorous aseptic conditions; demerol was given as a sedative. The operation was done under simple infiltration anaesthesia, and the method was dilatation and curettage. No patient over twelve weeks was accepted. My youngest patient was 14 years of age. She was brought to me by her parents on the recommendation of another physician. My oldest patient was aged 47 years. I aborted the same woman eight times, without incident. She refused to be sterilized. It was against her beliefs as she was Roman Catholic. I am unalterably opposed to the institution of Abortion Committees. They waste too much valuable time. Furthermore, there are no such things as Appendectomy, etc. Committees.
>
> As far as I am concerned, abortion is a matter between a woman and her physician, and in the final analysis concerns the woman alone, if her physician will not serve her she should be sent to one who will, soonest! Time which is of the essence should not be wasted.
>
> • • •
>
> I have personally performed over 1,000 illegal first trimester abortions between 1967 and 1970.
>
> I am vehemently opposed to forcing hospitals to set up abortion committees when its personnel and doctors are substantially opposed. Of course, no staff should be forced to cooperate in any hospital or clinic, against their will. I now see few patients. But even then, when I meet women who are now much more in evidence who project an honesty and warmth and iconoclastic humour that has absorbed this new view of the cosmos, it is almost past the agony of indignation at the oppression they have suffered from male authority—political, social, ecclesiastical.

The Abortion Squad of the Morality Department of the Metropolitan Toronto Police estimated that thousands of criminal abortions were procured

annually in that area. Informal routes were well known. It was part of the folklore of the times that women were advised to "go to visit their aunts (or uncles) in _____ ". Most of the illegal abortionists were women. Several of the physicians who did abortions were reported to have been highly respected members of the medical profession, on occasion, a head of a hospital department, or the chief of medical staff.

Many family doctors and obstetrician-gynaecologists whom the Committee met across Canada reported that they had treated a high incidence of complications resulting from induced abortions. Prior to the change in the Abortion Law the hospital insurance statistical reporting system which documented the extent of reported complications resulting from illegal abortions was little used by health authorities or the medical profession. When visited by the Committee, none of the provincial health departments had any formal knowledge, past or present, of the scope of illegal abortions. The existence of known abortionists indicates that those practitioners who were felt to be competent were often tolerated as a necessary "social evil", a safety valve whose existence was allowed to preclude the flagrant incompetence of quacks.

TABLE 4.5

CRIMINAL CHARGES AND CONVICTIONS FOR INDUCED ABORTION: CANADA 1900-1972*

STATISTICS CANADA

Year	Charges	Convictions	Percent Convictions/ Charges
1900-1910	97	33	34.0
1911-1920	172	87	50.6
1921-1930	210	115	54.8
1931-1940	427	271	63.5
1941-1950	358	243	67.9
1951-1960	254	194	76.4
1961-1970	267	204	76.4
1971-1972	8	8	100.0
TOTAL	1,793	1,155	64.4

*Justice Statistics Division, Statistics Canada.

Between 1900 and 1972 there were 1,793 individuals charged with procuring or attempting to procure an abortion of whom 1,155, or 64.4 percent were convicted. The highest incidence of charges was during the decade of the Great Depression of the 1930s. The rate dropped substantially during the 1940s and levelled off during succeeding decades. During 1971 and 1972, there were eight individuals charged, all of whom were convicted. In 1969 the number of convictions dropped to nine from the total of 34 recorded in 1968. There were two convictions in 1972. While the number of persons who were charged over the period of seven decades took the form of a bell-shaped curve, low-high-low, the proportion of convictions rose steadily from 34.0 percent between 1900 and 1910 to 76.4 percent between 1951 and 1970.

The review of the Index of Cases of the Judicial District of York County from 1933 to 1975 indicated that during this 43-year period, there were 110 charges of: procuring miscarriage; an illegal operation; abortion manslaughter; giving a drug to procure an abortion; or attempted abortion. There were 68 convictions, or 61.8 percent of the individuals who were charged were convicted. None of the women who sought or had an illegal abortion or who had been involved as patients of those individuals charged with procuring an abortion were themselves charged. Of the cases involving abortionists which came before judges sitting without juries, 52.9 percent were convicted, while 37.3 percent of the individuals who were charged who appeared before juries in the Sessions Court were convicted. The 110 charges involved 97 individuals with five persons being charged twice at different times and four individuals being charged three times. The majority of the persons charged (94.8 percent) were laymen. Five physicians were convicted with sentences of four months, eight months, nine months, one year, and 18 months.

There were 55 individuals charged between 1960 and 1967, or an average of seven each year. In 1968 one individual was charged and convicted, two in 1969, and two in 1971. For this judicial county as well as for the country, the number of criminal charges and convictions dropped substantially two years prior to the date when the amendments to the Criminal Code went into effect on August 26, 1969. Knowledgeable observers have suggested that this sharp decline resulted from three factors: a widely held anticipation that the Criminal Code would be amended; an increase in the number of hospitals which did therapeutic abortions and mounting pressures within the medical profession to make legal what was being done; and a redirection of the energy of enforcement agencies to other issues such as the control of drug trafficking. While the actual reasons for the decline in charges and convictions may not be fully clear, there is no doubt that after reaching a peak between 1966 and 1967, a sharp decrease did occur during 1968. Representing only one measure, an incomplete one if taken by itself of the extent of illegal abortion, the trends in charges and convictions for this offence has involved only a handful of cases since 1971.

TABLE 4.6

CRIMINAL CHARGES AND CONVICTIONS FOR INDUCED ABORTION: JUDICIAL COUNTY OF YORK, 1933-1975*

Year	Charges	Convictions	Percent Convictions/ Charges
1933-39	9	8	88.9
1940-49	24	13	54.2
1950-59	17	11	64.7
1960-67	55	31	56.4
1968	1	1	100.0
1969	2	2	100.0
1970	-	-	-
1971	2	2	100.0
1972-75	-	-	-
TOTAL	110	68	61.8

*Source: Index of Cases of the Judicial District of York, 1933-1975.

Listed Therapeutic Abortions in Non-Committee Hospitals. Because the analysis of the information on the distribution of patients related to the hospitals with committees and hospitals without committees required an extensive re-working of the statistical records maintained by Statistics Canada, this analysis was only done for four provinces (New Brunswick, Quebec, Saskatchewan, and British Columbia) in different regions of the country. The purpose of the analysis was to determine the proportion of women who had this procedure done locally or in other hospitals in a province.

This analysis indicated that a number of abortions which were coded as therapeutic abortions (codes 640-641 of the *International Classification of Diseases*) were listed as having been done in hospitals without committees. In compiling its hospital morbidity records, Statistics Canada reports directly the coding of diseases provided by hospitals. Operating under the terms of the *Statistics Act, 1971,* Statistics Canada in its handling of information adheres to Section 16(1)(b) which stipulates:

> No person who has been sworn under section 6 shall disclose or knowingly cause to be disclosed, by any means, any information obtained under this Act in such a manner that it is possible from any such disclosure to relate the particulars obtained from any individual return to any identifiable individual person, business or organization.

In the context of these regulations, no identification by the Committee was possible of the hospitals involved to determine whether the cases reported were errors in the coding of these abortions or whether these were illegal abortions. **A total of 42 reported therapeutic abortions were done in hospitals without therapeutic abortion committees in four provinces in 1974.** There has been no review of the distribution of these reported induced abortions by provincial health authorities or Statistics Canada. The extent to which this listing occurs in the other six provinces and the two territories is unknown.

Volume of Illegal Abortion. Four sources of information were used to develop estimates of the extent of illegal abortion. These sources were: (1) information obtained from site visits to 140 hospitals by the Committee; (2) estimates of the prevalence of illegal abortion by physicians based on their own experience in medical practice; (3) the prior experience with induced abortion of patients in the national patient survey in Canada and a small group of Canadian women who had abortions in the United States; and (4) individuals reporting they had had illegal abortions who were interviewed in the national population survey.

The administrators, senior medical staff, and obstetrician-gynaecologists whom the Committee met at 140 hospitals in all provinces and the two territories reported that while the prevalence of deaths and complications resulting from illegal abortion had been high in the 1950s and 1960s, there had been no recent deaths attributed to illegal abortion at these hospitals. The complications associated with illegally induced terminations of pregnancy had virtually disappeared. Most of the physicians at these hospitals concluded that illegal abortions either were not now being done, or if this were the case, they were done so well that there were no deaths and few associated complications.

Physicians in the survey of family doctors and obstetrician-gynaecologists were asked what proportion of women in the community where they practiced obtained illegal abortions. A majority of both medical specialties (78.4 percent family physicians, and 68.3 percent obstetrician-gynaecologists) said they knew no patients who had had illegal abortions. A slightly higher number of obstetrician-gynaecologists (31.1 percent) than family physicians (19.9 percent) estimated that between 0 and 20 percent of women seeking abortion had this operation done illegally. A small number of physicians (0.49 percent) estimated that between 80 and 100 percent of the abortions were procured from illegal sources. Most of the physicians who reported a high number of illegal abortions practiced either in Ontario (23.5 percent) or in Quebec (58.8 percent).

Canadian women who had abortions at clinics or hospitals in the United States were asked if they had had a previous abortion, and if so, where and by whom it had been done. A small number (2.9 percent) had had illegal abortions done in doctors' offices in Canada. Of the total of 4,754 women in the national patient survey, 17.9 percent had had a previous abortion. For these women 73.9 percent had had this procedure done in a Canadian hospital, 9.8 percent at a clinic in the United States, 4.0 percent in a physician's office in Canada, and 2.4 percent from non-medical sources in Canada.

Calculated on the basis of rates per 1,000 women in the national population survey, the experience of women with illegal abortion varied by their age. For teenagers between 15 and 17 years, none reported having had an illegal abortion done in a doctor's office or induced by a layman. For older women this rate rose to 3.4 per 1,000 between 18 and 23 years, 6.2 per 1,000 between 24 and 29 years, 12.6 per 1,000 between 30 and 49, and 2.2 per 1,000 over age 50. The overall rate for women in the reproductive years of 15 to 49 was 6.6 per 1,000, a rate which was divided between illegal abortions done in doctors' offices (4.3 per 1,000) and induced by laymen (2.3 per 1,000).

The Committee has found in the work done for this inquiry that abortion is not a subject about which women easily talk when it relates to their personal experience. It is for this reason that the rate of 6.6 per 1,000 women who said they had had an illegal abortion can be regarded as a minimal estimate. If these rates are projected on an age-specific basis by developing different rates for each age category, then it is estimated that 46,096 Canadian women between the ages of 15 and 49 years have had illegal abortions. This estimate excludes women who have attempted self-induction or had abortions done in the United States.

Women in the national population survey were asked whether they had tried or had a self-induction. Section 251(2) of the Criminal Code provides that:

> Every female person who, being pregnant, with intent to procure her own miscarriage, uses any means or permits any means to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years.

For all women in the national population survey, the rate per 1,000 who reported a self-induction was 8.5 and for specific age categories the rates were:

none for teenagers between 15 and 17 years; 6.8 per 1,000 between 18 and 23 years; 15.8 per 1,000 between 24 and 29 years; 5.0 per 1,000 between 30 and 49 years; and 15.5 per 1,000 for women over age 50 years. When these rates are projected on an age-specific basis it is estimated that 55,061 women in Canada had tried or had a self-induction.

The lower rates of illegal abortions among younger women corresponds with the decline in reported deaths and complications associated with illegal abortions and the number of charges and convictions of persons procuring illegal abortions. The information obtained from women in the national patient survey, while less representative of the total population than the national population survey, found similar trends by the ages of these patients.

The terms of the amended Abortion Law went into effect on August 26, 1969. If women between 18 and 23 years are considered with the current number of teenagers between 15 and 17 years, 3.4 per 1,000 in this age category had had an illegal abortion procured by a physician or a layman. The rate of self-induction for these ages was 6.8 per 1,000. This group of women between 15 and 23 years in 1976 represents those women in the reproductive years who would be affected if they sought an abortion under the amended legislation. In contrast, for women over the age of 24 years the rate of illegal abortions was 8.3 per 1,000 and 10.2 per 1,000 had tried self-induction. Unlike these older women over the age of 24 years, most younger women (15 to 23 years) had abortions either in a Canadian hospital or went to the United States for this operation. For the women in this national population survey, **one direct consequence of the amended abortion law was the sharp reduction of illegal abortions among teenagers and young women.**

Out-of-country abortions

Where and how Canadian women have obtained induced abortions has changed during recent decades. Overall during this period there has been an absolute increase in the reported induced abortion rate. From several sources of information including personal experiences provided by women to the Committee, judicial records, and the national population survey, women seeking abortion from the time of the Great Depression of the 1930s to the mid-1950s tried self-induction, turned to untrained abortionists, or had this operation done in a physician's office. Women now in their seventies and eighties have told or written to the Committee of their anguish and fears of coping with an unexpected or unwanted pregnancy. Getting an induced abortion was expensive. Because it was considered immoral and illegal, it was not discussed publicly. Few women who had abortions by these means told their friends or relatives, often not even members of their families. The stakes were high in terms of risks to moral and social standing and to permanent injuries to a woman's health.

As the abortion laws of other nations were modified after World War II, a few Canadian women, mainly those from families with higher than average

incomes, went abroad to get abortions. During the 1950s a number of Canadian women seeking abortions were referred by their physicians for this purpose to Japan, Sweden, Poland, and the United Kingdom.

Under the 1938 Act in Sweden, induced abortion could be approved on medical grounds when childbirth would entail: serious danger to a mother's life or health; physicial defect or weakness of the woman; on social grounds involving rape, incest, or pregnancy under age 15; and on eugenic grounds. This legislation was amended in 1946 to include a socio-medical indication involving a "woman's conditions of life and her circumstances in other respects." On the basis of these changes in the Swedish legislation, some Canadian physicians counselled their patients to seek abortions in that country. The women who did so were ill-advised. Regulations established by the Swedish National Board of Health virtually precluded the authorization of abortions for aliens.

> Aliens registered at the annual census and liable to taxes in Sweden come under the abortion law and may seek permission for abortion through the counselling centers. Other aliens have little chance of getting an abortion in Sweden. Every application must be drawn up according to law, and must include a certificate from a licensed Swedish physician. The Board will not consider a written petition with a certificate from a foreign physician or institutions or help with an application. If the woman comes herself to the Board, all the Board can do is to recommend her to ask the representatives of her country in Sweden for the address of a Swedish physician or to try to get hold of one herself. When a foreign woman applies in the regular way on the purely medical grounds of disease or disability, the Board sometimes gives permission for abortion in Sweden. When she applies on other grounds, they are generally prevented from doing so, mainly because they are unable to get a true picture of the conditions under which she lives.[9]

To preclude "the heartbreak and experience of a fruitless journey to Sweden", there was consideration of this issue between the senior officials of the Department of External Affairs, the Department of National Health and Welfare, and the Canadian Medical Association. Several articles appeared in professional journals and newspapers which described the Swedish regulations as they applied to aliens. A number of Canadians who went to Sweden for induced abortions subsequently had this operation done in Poland or the United Kingdom.

Combined with the trend of more women going abroad for abortions, there was an increase at this time in the number of women who obtained illegal abortions in Canada. The highest rate known to the Committee for illegal abortions was 12.6 per 1,000 women who were between 30 and 49 years of age in 1976. When these women were in their twenties and early thirties, they had obtained abortions from laymen in their homes (3.8 per 1,000) or physicians in their offices (8.8 per 1,000). This trend coincided with an increase in the number of convictions for procuring an illegal abortion. The number of doctors

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[9] Correspondence made available to the Committee. See also: R. L. Liljeström, *A Study of Abortion in Sweden*, Stockholm, Kungl. Boktryckeriet P.A. Norstedt & Söner, 1974. A contribution to the United Nations World Population Conference.

involved in doing illegal abortion increased. At several large hospitals across the country professional review procedures, often involving senior medical staff, were established to review abortion applications. A number of physicians who were at the time involved in this procedure told the Committee that they had been prepared to risk their professional careers had they been convicted because they believed that unless adequate medical care was given, women seeking induced abortions would resort to "incompetent butchers".

Two changes which occurred within a year had a profound impact on where Canadian women went to get abortions. The amended Canadian legislation went into effect toward the end of 1969. In 1970 several states in the United States revised their abortion statutes. During the years that followed these changes in legislation in Canada and the United States, major shifts took place involving where women obtained induced abortions in Canada and abroad.

While their numbers have never been fully known, fewer Canadian women at the start of the 1970s went to Europe for abortion. The number of Canadians who obtained legal abortions in the United Kingdom declined in successive years from 376 in 1969, 297 in 1970, 67 in 1971, 52 in 1972, 34 in 1973, to 24 in 1974. As hospitals across Canada established therapeutic abortion committees, a larger number of women than before sought approval for induced abortion at these facilities. Where such committees did not exist, or for a combination of other reasons women could not obtain abortion where they lived, abortion referral pathways emerged which channelled Canadian women to abortion clinics and offices in the United States. Most of these roads initially led to New York City and upstate New York cities adjacent to the international boundary. As other states amended their abortion legislation, several major north-to-south routes emerged.

Provincial medical care insurance commissions pay for the fees involved in the abortion procedure if this operation has been done in a provincial hospital, if patients retain their provincial residence status when this procedure is done in hospitals in other provinces and if it is considered a "required" medical procedure. The regulations governing the payment of medical services which may be obtained by Canadians when they are abroad vary among the provinces. In general, the payment for elective procedures is not reimbursed. Where emergencies occur or when patients are specifically referred to foreign medical centres on the written authorization of a physician, some provinces make provisions for the payment of these services based on the approved provincial medical fee schedules. Because the number of such requests for reimbursement is limited, most provinces do not separately record these payments in their statistical classification systems.

Provincial health authorities were asked to provide the Committee with information about the number of abortion patients who were residents of the provinces for whom payment had been made for abortions obtained out of the country. This information was not available for six provinces. Between 1970 and 1975, the costs of 124 abortions which had been obtained by Canadian women outside Canada were reimbursed at provincial medical fee schedule rates by four provinces. Based on the number of women reported by Statistics

Canada to have had abortions outside Canada in 1974, a number which in terms of information obtained by the Committee is an underestimate, the 22 cases for that year for which reimbursement was made represented 0.51 percent of women who had abortions outside the country.

Reported Abortions in the United States. In 1971 Statistics Canada received information from the State of New York that 3,849 Canadian women had obtained abortions in New York City. Information for the rest of New York State for that year was not available. In 1972, 6,167 Canadians had abortions in the State of New York. Little was known about the number of Canadian women who might have obtained abortions in other states. In some instances state statutes invoked residency requirements, while in other cases no statistical records were kept concerning aliens. The Abortion Surveillance Branch, Centre for Disease Control of the U.S. Public Health Service, which coordinated the compilation of national statistics on abortion for the United States relies on state health authorities for its information about the number of aliens obtaining abortions. Based on information received from this Branch and state health authorities, Statistics Canada concluded that "because of residency requirements and other factors, the number of Canadian residents who received therapeutic abortions in other states during 1972 is thought to be very small."

From 1972 to 1974 the total number of Canadian women who had abortions in the United States listed by the U.S. Public Health Service and state health authorities dropped from 6,167 to 4,699, or by 23.8 percent.[10]

Place Abortion Performed	Number of Canadian Women, 1974
California	8
Hawaii	1
Michigan	242
Minnesota	169
New York State (excludes New York City)	2,855
New York City	1,319
South Dakota	7
Vermont	95
Virginia	3
TOTAL	4,699

While the number of Canadians getting abortions in upstate New York had risen, there was a sharp decline in the number of women going to New York City for abortions. In its report on *Abortion Surveillance 1974* the U.S. Public Health Service listed 5,339 out-of-country residents who had had abortions in the United States in 1974.

[10] Abortion Surveillance Branch, Center for Disease Control, United States Public Health Service, Atlanta, Georgia, 1976. This updated information for 1974 supersedes out-of-country listing obtained from the same source given in: Statistics Canada, *Therapeutic Abortions, Canada, 1974: Advance Information.*

The move of Canadian patients away from New York City to clinics in upstate New York represents a dispersion of abortion services in the United States resulting from amended legislation in other states. One administrator of a large abortion office in New York City estimated that between 1970 and 1972 some 40 clinics in that city provided abortion services for women who came from across the United States as well as from several Canadian provinces. As new abortion services were started elsewhere in the United States and some hospitals in Canada established therapeutic abortion committees, the volume of abortion patients who were seen in clinics in New York City decreased sharply. In 1971 there were 268,573 reported abortions done in the State of New York, a number which rose to 299,891 in 1972, and dropped to 161,521 by 1974. Between 1971 and 1974 there was a 39.9 percent decrease in the number of abortions done in the state. The number of abortions done in other states adjacent to Canada increased as for instance in Vermont, which had nine reported abortions in 1971 and 1,930 in 1974.

Migrating Pathways. The abortion clinics which were contacted in the United States were asked to provide statistics, or if these were unavailable, estimates of: the number of Canadian women who had abortions at the clinic, hospital, or office in 1975; the total number of abortions done in 1975; the residence of Canadian patients; and by whom they had been referred. The information received by the Committee from clinics in the United States was incomplete (56.1 percent replied). The reasons why some clinics did not provide information to the Committee on the number of their Canadian patients included: inadequate patient record systems; distrust of any government-sponsored study which might document the number of alien patients for income tax purposes in the United States; the preservation of special arrangements, including fee-splitting, with some Canadian-based abortion referral agencies; and an attitude that it was not in their business interest to provide information which it was felt might make the obtaining of induced abortions more accessible in Canada. A number of these centres located in New York City and upstate New York which were well known to Canadian agencies did not provide information. For these reasons the information obtained from these sources by the Committee about the number of Canadians getting abortions in the United States in 1975 was a minimal estimate.

The changes involving the places where Canadian women went to get abortions in the United States were enmeshed in a strong competition to attract these patients among some of the clinics located in states along the international boundary. At least 6 of the 40 clinics visited by the Research Staff of the Committee had been established primarily to serve Canadian patients. In one instance the attending physicians routinely flew from New York City to do abortions in an upstate clinic. At another clinic, the physician-owner who had invested over $200,000 in his facility, said it would be a disaster if the Canadian law on abortion were to become more liberal for he would be put out of business. At many of the clinics, while their staff knew little about the staffing, the facilities, or services of their competitors, their administrators and medical staff downgraded the quality of care which was given elsewhere. The fees for abortion were often set competitively.

In reviewing the work of the 40 abortion clinics in the United States used by Canadian women, four measures of the quality of care were qualitatively assessed. These measures were: (1) general appearance of facilities; (2) the training of medical staff and the training and number of support staff; (3) the facilities and/or arrangements which were made for the emergency care of patients; and (4) the patient chart procedures and record systems. The staffing and services of these clinics ranged from sparsely furnished and equipped offices staffed by a receptionist, a nurse, and a part-time physician to major clinical facilities and services operated directly by hospitals. At least two of the 40 clinics were not operating within the terms of state licensing statutes.

There were no uniform standards established for the operation of these abortion services which ranged from physicians' offices to in-patient hospital facilities. The surveillance of the clinics in the United States by state health authorities was often non-existent, or operated at minimal levels requiring the perfunctory reporting of statistical information. In 1974, 36 states collected information on induced abortions, while 15 states had less complete reporting systems. On the basis of the number of Canadian women listed as patients by clinics and the number of Canadian women reported by state and federal agencies in the United States, this statistical auditing procedure is inaccurate and incomplete. The reported abortion rates of states such as Maine, Vermont, New York, and North Dakota were substantially inflated by a proportionately large number of Canadians getting abortions in these states, while in the case of these and other states, the Committee's findings indicate that a sizeable number of Canadian patients were not recorded in official state abortion statistics.

Four of the abortion services were based in hospitals, one had a full range of clinical facilities, and seven were located immediately adjacent to a hospital. Over half (58.6 percent) of the abortion clinics used by Canadian women in the United States had no formal affiliation with a hospital to provide for emergency services for patients, if abortion operation complications arose.

Most of the Canadian patients using the abortion clinics in the United States were reported by these centres to have been referred by Canadian physicians (55.5 percent) and community referral agencies (25.8 percent). One out of five Canadian women (18.7 percent) learnt about the clinics from friends, advertisements in Canadian newspapers, or toll-free telephone directory listings. Half of the clinics (48.3 percent) did not advertise their services, while the remainder used a variety of means to solicit Canadian patients. These methods, which sometimes included more than one approach, were:

providing brochures on request	13.8 percent
letters written to Canadian doctors	34.5 percent
letters written to Canadian referral agencies	24.1 percent
listings in Canadian telephone directories	13.8 percent
visits to Canadian agencies	10.3 percent
other	3.5 percent

Staff members of a number of Canadian referral agencies from time to time visited abortion clinics in the United States to review the range of services provided for patients. On the basis of these visits patients from Canada were selectively routed to those clinics which it was felt provided a good quality of medical care. No such visits were reported to have been made by Canadian physicians who referred patients to these clinics. Their decision to refer patients to these abortion clinics was based on letters and advertisements outlining the services which were provided. With the exception of abortion clinics in New York City, 62 clinics in each of the five regions in the United States drew Canadian patients who lived in nearby provinces.

1. Maritimes to New England and New York City.

   Maine: Bangor, Bar Harbour, Brunswick, Portland.
   Massachusetts: Boston, Brighton, Springfield.

2. Quebec to Mid-Atlantic States and New York City.

   Vermont: Burlington, Morrisville, Rutland.
   Upstate New York: Albany, Dobbs Ferry, Malone, Plattsburg, Syracuse, Tarrytown, Watertown.

3. Ontario to Western Upstate New York and Great Lakes' States.

   Illinois: Chicago.

   Michigan: Ann Arbor, Detroit, Grand Rapids.

   Upstate New York: Buffalo.

4. Manitoba to Midwest States.

   Minnesota: Minneapolis, St. Louis Park.

   North Dakota: Grand Forks.

5. Western Provinces to Northwest States.

   California: Oakland, San Jose.

   Washington: Bellingham, Renton, Seattle, Spokane, Tacoma.

Information from 62 clinics in the United States indicated that an estimated 6,957 Canadian women had obtained abortions at these centres in 1975. Based on 1974 figures provided by Statistics Canada,[11] there were 48,136 abortions. Added to this number for 1974 were 4,699 Canadian women who were reported by Statistics Canada to have had abortions in the United States. In the survey done by the Committee, clinics in 12 states and the District of Columbia listed 6,957 Canadian patients whose distribution was: California (6), Illinois (33), Kansas (10), Maine (156), Massachusetts (177), Michigan (975), Minnesota (154), Montana (0), North Dakota (171), New York (3,982), Vermont (280), Washington, D.C. (1), and Washington (1,012).

Estimates on the residence of Canadian patients were derived from three types of information provided to the Committee by abortion clinics in the

[11] Information on the number of therapeutic abortions done in Canadian hospitals was not available for 1975 at the time of this inquiry.

United States. These were: (1) statistical records maintained by the clinics; (2) estimates made by clinic administrators where patients from Canada lived; and (3) when residence information was omitted about the number of Canadians listed, an estimate was based on where the clinic was located and the provincial distribution of patients was distributed on a proportional basis of other clinics within the region. These estimates are given in Table 4.7 which also lists the 1974 ratio of abortions per 100 live births by province given by Statistics Canada and this ratio recalculated to include the number of Canadian women who obtained abortions in the United States in 1975. Based on this measure the national ratio rose from 13.9 to 15.9 or by 14.4 percent. The ratio changed the least in the provinces which had the highest listed abortion ratios, and it rose the most in those provinces listed by Statistics Canada which had the lowest reported induced abortion ratios. The changes in the ratios of induced abortions (combining experience for Canada and the United States of Canadian women) per 100 live births by province were:

	Percent Change
Newfoundland	22.2
Prince Edward Island	19.2
Nova Scotia	22.0
New Brunswick	57.9
Quebec	73.1
Ontario	7.0
Manitoba	23.2
Saskatchewan	12.8
Alberta	12.9
British Columbia	3.5
CANADA	14.4

TABLE 4.7

RESIDENCE OF CANADIAN PATIENTS GETTING INDUCED ABORTIONS IN THE UNITED STATES*

SURVEY OF CENTRES IN THE UNITED STATES

Province	Number of Induced Abortions		Ratio of Induced Abortions per 100 Live Births	
	Statistics Canada Listing 1974	Canadian Residents in U.S.A. 1975	Statistics Canada Listing 1974	Revised Listing Including Out-of-Country Abortions
Newfoundland	184	42	1.8	2.2
Prince Edward Island	50	10	2.6	3.1
Nova Scotia	1,062	234	8.2	10.0
New Brunswick	440	250	3.8	6.0
Quebec	4,453	3,277	5.2	9.0
Ontario	24,795	1,795	20.0	21.4
Manitoba	1,411	334	8.2	10.1
Saskatchewan	1,176	154	7.8	8.8
Alberta	4,391	546	14.7	16.6
British Columbia	10,024	315	28.3	29.3
CANADA	48,136	6,957	13.9	15.9

*Estimates for the Yukon and Northwest Territories could not be made from information provided by clinics in the United States.

Based on the reports of community agencies referring patients to clinics in the United States and clinics visited by the research staff of the Committee which refused to provide information, but which were known to serve Canadian women, the Committee estimated that between 10 and 20 percent more Canadian women than for whom information was available had abortions in the United States. If the reported number of 6,957 patients is recalculated on this basis, the number of Canadian women who had abortions in the United States in 1975 is estimated to have been between 7,655 and 8,351, or between 15.9 percent and 17.3 percent of the total number of abortions done in Canadian hospitals in 1974. Based on these estimates between 45,930 and 50,106 Canadian women obtained induced abortions in the United States between 1970 and 1975.

These trends are confirmed but at a somewhat higher level by the findings of the *national population survey* obtained from women who said they had had induced abortions in the United States. For every four women who said they had had an abortion in Canada, one woman said she had obtained an abortion in the United States, (ratio of 4.3:1). On this basis in 1974 there would have been an estimated 11,194 Canadian women that year who had induced abortions in the United States.

These estimates of the number of Canadian women getting abortions in the United States between 1970 and 1976 were derived from different sources of information. What their general proportions indicate is that a substantial number of Canadian women each year, at least between 15.9 percent and 23.5 percent of women obtaining abortion procedures annually in Canadian hospitals, obtained induced abortions in the United States.

Volume of induced abortions

There are three known sources of induced abortions obtained by Canadian women and one potential source which may involve induced abortions. The known sources are: (1) therapeutic abortions in Canadian hospitals; (2) illegal abortions; and (3) out-of-country abortions. A fourth potential source of induced abortions may be those abortions which are classified as being neither induced nor spontaneous. Reliable information is only available for the number of therapeutic abortions done in Canadian hospitals which have been approved by therapeutic abortion committees. For the other three sources of abortions, estimates have been based on information obtained by the Committee. The base year of 1974 is used in deriving rates as this is the last year for which there was a full tabulation available of the various categories of abortion.

Based on the national population survey, age-specific ratios were calculated which derived an estimate of 46,096 illegal abortions obtained by women between the ages of 15 and 49 years. None of the women between 15 and 17 years reported having had an illegal abortion. If the experience of women between 18 and 49 years is considered, then there were on an average 1,441 illegal abortions every year. When these illegal abortions are considered in

terms of live births, they represented for 1974 a ratio of 0.4 illegal abortions per 100 live births.

A total of 6,957 abortions obtained by Canadian women were reported by clinics in the United States in 1976. The Committee estimated that the actual number of Canadian women getting abortions in the United States was between 10 and 20 percent higher, or respectively 7,655 and 8,351. In the national population survey the proportion of out-of-country abortions was 23.5 percent of induced abortions obtained in Canadian hospitals, or for 1974, 11,194 abortions. As it was known that many clinics in the United States did not provide information to the Committee, an estimate of 20 percent is taken as the basis of the number of Canadian women who obtained induced abortions in the United States. In terms of 345,645 live births in 1974 this results in a ratio of 2.8 out-of-country induced abortions per 100 live births.

When the estimates of the three known sources of induced abortion are combined, they represent a ratio of 17.1 induced abortions per 100 live births for 1974.

Type of Induced Abortion	Number	Rate per 100 Live Births
therapeutic	48,136	13.9
illegal	1,441	0.4
out-of-country	9,627	2.8
TOTAL	59,204	17.1

The estimate of 17.1 induced abortions per 100 live births is 23.0 percent higher than the number of therapeutic abortions reported to have been done in Canadian hospitals.

In 1973 there were 34,911 abortions classified by Statistics Canada as spontaneous (5,970) and abortions not specified as induced or spontaneous (28,941). The rates for these two categories of abortions varied considerably between the provinces, the size of hospitals, and the ownership of hospitals. In deriving an estimate of how many of these abortions may represent assisted or induced abortions, the Committee assumed that the ratio of these abortions per 100 live births which were reported by religious hospitals represented a minimum baseline. Because of the stated position of these hospitals on the issue of induced abortion, it was assumed that the ratio of 7.1 per 100 live births may more accurately reflect the number of abortions occurring from natural causes than may be the case in hospitals which were not known to endorse these principles. On this basis there would have been 24,276 spontaneous and other abortions in 1973 in Canada instead of the 34,911 which were reported. If the remaining 10,635 abortions which were listed for that year as spontaneous and other are considered as abortions which may have been "assisted", they would represent 3.1 induced abortions per 100 live births in 1973. When this ratio is added to the revised ratio of 17.1 per 100 live births in 1974, it results in a combined ratio of 20.2 per 100 live births.

The total number of induced abortions obtained by Canadian women in 1974 consisted of: (1) therapeutic abortions done in Canadian hospitals (48,136); (2) illegal abortions obtained in Canada (1,441); (3) induced abortions obtained in the United States (9,627); and (4) "assisted" abortions classified under other listings (10,635). The total of 21,703 induced abortions which were not obtained under the procedures set out in the Abortion Law was 45.1 percent higher than the reported number of therapeutic abortions for 1974. For every five live births in Canada in 1974, it is estimated there was one induced abortion (20.2 induced abortions per 100 live births).