Twenty one years of legal abortion

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The 1967 Abortion Act received royal assent on 27 October 1967 and came into force six months later. So 27 April 1989 marks its 21st anniversary; this article reviews its effects.

The act had a long gestation. As far back as 1933 the chief medical officer stated in his annual report, "There is also, it is to be feared, a substantial increase in abortion, and in the habit of abortion... which is now materially affecting maternal mortality."[1] Two years later the BMA set up a committee led by Professor James Young of Edinburgh University to look at the medical aspects of abortion. It recommended a change in the law to allow abortion on the grounds of a threat to the physical or mental health of a woman and suggested that abortion should be considered in cases of rape, if a girl was under the age of consent, and on eugenic and social grounds.

In 1936 the Abortion Law Reform Association was set up by a small group of women, including Dora Russell and Frida Laski. In 1937 the government set up the Birkett Committee to consider the question, and the following year Dr Joan Malleson referred a 14 year old girl who had been raped by two soldiers to Mr Aleck Bourne, who performed the abortion and presented himself to the police. His subsequent trial and acquittal allowed some abortions to be performed legally, but although the Birkett Committee recommended a change in the law, the second world war intervened. Legislation had to wait, indeed, until the late 1960s, and even then it was based on a private member's bill introduced by David Steel.[1]

Numbers of abortions

Since the legislation almost three million abortions have been carried out on women living in England and Wales and 170 000 on Scottish women. The law does not extend to Northern Ireland, but 24 000 women from Northern Ireland are known to have travelled to England for abortions, as have 50 000 women from the Republic of Ireland.

The act was not backed up by any specific allocation of money for facilities or staff within the NHS, and the service provided has varied from district to district, depending on the attitudes of the consultants concerned. Nevertheless, the number of abortions rose rapidly in the late 1960s and early 1970s (table I). This process had slowed down by 1974, when the number of abortions fell for the first time. The introduction of free contraception seems to have had an important effect; the number of abortions fell by nearly 9000 from 1973 to 1976, and the rate of abortion fell from 11·4 to 10·5 per thousand women aged 15 to 44.[2] The number rose in 1977 and 1978, possibly owing to adverse publicity about the side effects of oral contraceptives. For the past five years the number of abortions in each successive year has risen. The reasons for this are likely to be complex.[3]

Table II shows that the rate of abortion in Scotland, although lower than that in England and Wales, has risen steadily since 1969.[4] The rate for each year is increased when the numbers of Scottish women having abortions in England and Wales are taken into account.

The known rate of conception per thousand married women aged 16 to 44 fell from 105 in 1969 to 85 in 1985, whereas the proportion of pregnancies ending in abortion rose from 4·0 to 6·3 per thousand married women. Among unmarried women the rate of conception fell from 56·2 and 62·6 per thousand in 1969 and 1970 respectively to 47·3 per thousand in 1976 and rose again to 60 per thousand in 1985. The rate of abortion rose from 9·6 per thousand in 1969 to 22·2 per thousand in 1985. These data show that since the mid-1970s about 40% of conceptions outside marriage have ended in abortion. The numbers of pregnant women

TABLE I—*Number (thousands) of abortions in England and Wales among residents and non-residents during 1969-88*

Year	Residents: Total No of abortions	Residents: Abortions performed within NHS	Residents: Abortions performed in private and charitable clinics	Residents: All abortions	Residents: Rate of abortion per thousand women aged 15-44	Non-residents
1969	54·9	33·6	16·3	49·9	5·3	5·0
1970	86·6	47·4	28·6	76·0	8·0	10·6
1971	126·8	53·5	41·1	94·6	10·0	32·2
1972	159·9	56·9	51·7	108·6	11·3	51·3
1973	167·1	55·5	55·1	110·6	11·4	56·6
1974	162·9	56·1	53·4	109·5	11·4	53·5
1975	139·7	51·0	55·3	106·2	11·0	33·5
1976	129·7	50·6	51·3	101·9	10·5	27·8
1977	133·0	52·6	50·1	102·7	10·4	30·3
1978	141·6	55·0	56·8	111·8	11·3	29·7
1979	149·7	55·6	65·1	120·7	12·0	29·1
1980	160·9	60·6	68·3	128·9	12·6	32·0
1981	162·5	61·1	67·5	128·6	12·4	33·9
1982	163·0	62·4	66·1	128·5	12·2	34·5
1983	162·2	62·6	64·8	127·4	11·9	34·8
1984	170·0	64·8	71·6	136·4	12·7	33·6
1985	171·9	65·2	75·9	141·1	13·0	30·8
1986	172·3	67·5	80·2	147·7	13·4	24·7
1987	174·3	69·4	86·8	156·2	14·1	18·1
1988*	182·8	66·8	99·9	166·7	14·8	16·0

*Predicted from data for nine months.

TABLE II—*Number and rate of abortions among Scottish women*[2,4]

Year	Abortions performed in Scotland: Number	Abortions performed in Scotland: Rate per thousand women aged 15-44	No of abortions performed in England and Wales	Total rate of abortions per thousand women aged 15-44*
1969	3544	3·5	NA	
1970	5254	5·2	190	5·4
1971	6332	6·3	524	6·8
1972	7600	7·5	835	8·4
1973	7498	7·4	1068	8·4
1974	7545	7·4	1026	8·3
1975	7300	7·1	1054	8·1
1976	7219	6·9	950	7·9
1977	7334	7·0	840	7·8
1978	7422	7·0	976	8·0
1979	7754	7·2	1028	8·2
1980	7905	7·3	1179	8·4
1981	9007	8·3	998	8·3
1982	8425	7·6	898	7·6
1983	8419	7·6	814	7·6
1984	9107	8·2	781	8·9
1985	9189	8·2	728	8·9
1986	10379	8·5	751	9·2
1987	10093	8·3	742	9·0

*Includes the abortions performed in England and Wales.

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who got married fell from 25 per thousand unmarried women in 1969 to 9·2 per thousand unmarried women in 1983.[5,6]

Impact on illegal abortions and maternal mortality

An important effect of the 1967 act has been to reduce the number of deaths due to illegal abortions. The absolute numbers of illegal abortions cannot be known with any certainty, but criminal abortion was common as far back as the middle of the nineteenth century: the *BMJ* campaigned against abortion in 1868.[7] In 1914 on the basis of surveys of behaviour the *Malthusian* suggested that 100 000 working class women had illegal abortions each year. In 1940 David Glass suggested that there were about 100 000 abortions a year,[8] and this figure is the one most commonly accepted for postwar years.[6,9]

In the 1960s gynaecologists in hospitals saw numerous women who had had incomplete abortions that were suspected of being illegally induced. Some women develop infection after a spontaneous abortion, but most cases of sepsis after abortion are due to illegally performed operations. The number of women discharged from hospital with a diagnosis of sepsis caused by an abortion was 3050 in 1965. By 1975 this figure had fallen to 710 and was down to 390 in 1982. In 1989 most young doctors who were trained in Britain have never seen a woman suffering or dying from the effects of a criminal abortion.

Another way of estimating the number of illegal abortions is by the number of police prosecutions. Once abortion became legal any sympathy for illegal abortion probably disappeared and the police, we suggest, would be more likely to prosecute when they uncover evidence. The number of associated offences recorded by the police fell from 314 in 1967 to seven in 1978, and the number of people convicted for performing illegal abortions fell from 190 during 1960-2 to two in 1987.[10]

Deaths related to abortion can be identified with much greater certainty. With the steady fall in maternal mortality associated with delivery in the 1950s abortion became the main cause of maternal mortality. In the first decade of legal abortion the proportion of all maternal deaths that were due to abortion fell from 25% to 7%. The number of recorded deaths due to abortion fell from 160 during 1961-3 to nine during 1982-4. There were seven deaths after legal abortions during 1982-4 and four during 1985-7.[2] In the 1970s more women died after abortions performed within the NHS than after abortions performed in private and charitable clinics, but more recently mortality from abortions within the NHS has fallen to a similar low level.[11]

TABLE III—*Proportion of abortions carried out within the NHS in England and Wales during 1980 and 1986 according to health region*

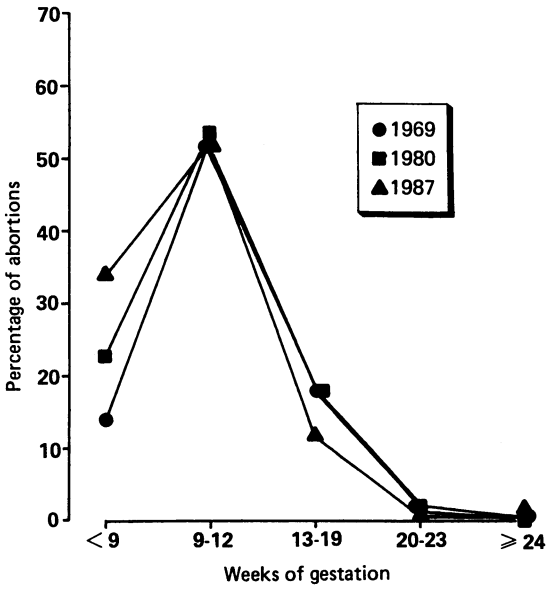
Regional health authority	% Of abortions carried out within the NHS	
	1980	1986
Northern	88·2	85·4
East Anglian	75·4	80·4
South Western	74·5	75·7
Wales	57·7	60·5
Trent	54·1	57·9
Oxford	50·9	49·0
North East Thames	49·9	46·0
Mersey	27·4	45·3
Wessex	50·6	42·8
North Western	42·1	41·1
South East Thames	48·2	40·5
Yorkshire	39·2	38·1
North West Thames	36·1	36·3
South West Thames	36·5	34·8
West Midlands	22·1	18·5
England and Wales	44·1	45·7

Regional variations in services

Twenty one years after the act was passed half of all British women having legal abortions pay for them. The regional differences in the provision of abortion services have persisted since 1968 (table III). For example, women in the Northern region are still more likely to have an abortion within the NHS than those in the West Midlands. The contrasts have been eased recently in some districts which have entered into an agency agreement whereby they pay a third party to perform the abortion, but this has made no difference nationally (just under 5% of women have free operations under an agency agreement). The number of women sterilised at the time of abortion has fallen in recent years, but there are still regional variations in the numbers having the combined operation both within the NHS and in private and charitable clinics.[12]

Gestation and method of operation

Initially the mortality from legal abortion was high. Long delays in performing the operations occurred often as gynaecologists referred women to psychiatrists for opinions about their mental health. Sterilisation was performed commonly at the time of hysterectomy in the second trimester. The figure shows that the proportion of abortions performed in the first trimester rose from 66% in 1969 to 86% in 1987; the proportions of early abortions in Britain, however, still compare poorly with other countries. In the United States



Period of gestation at which abortions were performed in England and Wales

women have been able to request abortion in the first trimester since 1974; by 1977 this had led to 91% of abortions being performed in this period. In Sweden, where abortion up to 18 weeks' gestation has been available on request since 1976, by 1980, 95% of abortions were done in the first trimester. In Denmark abortion on request up to 12 weeks was introduced in 1983 and 97% of abortions are done in this period.[13] In Britain the number of abortions performed at 20 weeks or later fell from 3% in 1968 to less than 1% in the 1980s. Legal abortions performed later than 24 weeks' gestation have always been few, but the total has fallen from an average of 100 a year in the 1970s to less than 30 a year since 1984 after advice from the Royal College of Obstetricians and Gynaecologists[14]; three quarters of these late abortions are done because of fetal abnormality.

The method of the operation is related to the stage of gestation in as much as vacuum aspiration alone cannot be used after 13 weeks. In the second trimester dilatation and evacuation, intra-amniotic or extra-amniotic infusion of various drugs, or surgical methods must be used. Table IV shows how the method of abortion has changed dramatically over the past 21 years. Nevertheless, regional differences in the surgical methods persist.

There may be considerable delays between a woman asking for an abortion and the procedure being carried out. The Lane Commission, reporting on the way the 1967 Abortion Act was working in 1974, showed that 79% of women had approached their doctor before eight weeks' gestation[15]; and Isobel Allen, in a study commissioned by the Department of Health and Social Security in 1977-9, documented the delays to which women are subjected.[16] The Royal College of Obstetricians and Gynaecologists and Department of Health and Social Security's study of late abortion in 1982

TABLE IV—*Methods of abortion performed in the second trimester during 1968 and 1987*

Method	1968* No (%) (n=8751)		1987† No (%) (n=20 398)	
Surgical:				
Vaginal hysterectomy	67		117	0·72
Abdominal hysterectomy	4104	49·8		
Hysterectomy	187		30	
Vaginal methods:				
Vacuum aspiration	1180		6482	
Vacuum aspiration and dilatation and curettage and evacuation		40·5	2713	53·4
Dilatation and curettage and dilatation and evacuation			1706	
Dilatation	2366			
Intrauterine methods‡				
Prostaglandins			3383	38·6
Prostaglandins and other drugs			4508	
Other medical			78	
Other and combined	835	9·5	1356	7·1
Other surgical§			17	

*Includes residents and non-residents of England and Wales.
†Includes only residents of England and Wales.
‡Not listed in 1968.
§Included saline (intrauterine method), Utus paste, and laminaria tents.

TABLE V—*Rates of legal abortion per thousand women aged 15-44 in most recent available year*[13]

Country	Year	Rate of abortion per thousand women aged 15-44
The Netherlands*	1984	5·6
Scotland	1984	8·9
New Zealand	1984	9·7
Hong Kong	1984	11·3
Finland	1983	12·1
England and Wales*	1984	12·8
Canada	1982	13·0
Tunisia	1985	13·6
Norway	1984	15·9
Sweden	1984	17·7
Denmark	1984	18·4
German Democratic Republic	1984	26·6
United States	1983	27·4
Singapore	1983	28·1
Czechoslovakia	1984	34·5
Hungary	1984	37·1
Cuba	1984	58·6
China	1983	61·5
Bulgaria	1984	61·9
Yugoslavia	1984	70·3
Romania	1983	90·9
Union of Soviet Socialist Republics	1982	181·0

*Residents only.

estimated on the basis of gynaecologists' reports from case notes that 45% of women operated on between 13 and 16 weeks' gestation and one fifth of those operated on after 20 weeks had seen their doctor before 13 weeks.[13] Gynaecologists have accepted day care slowly.[17]

Public and medical opinion

The 1967 Abortion Act was the first in a new wave of legislation in Western countries. In the discussion that led up to the act the Abortion Law Reform Association had decided (after a meeting at the House of Lords on 12 February 1964) not to press for women to have the legal right to choose an abortion in the early months of pregnancy. More recently other countries, including France, Italy, Holland, Canada, Tunisia, and the United States, have given women that right. In this respect British law has fallen behind that of other countries. The evidence of polls over the past 10 years suggests that the public would support a change in the law to give women a right to abortion in the first trimester. A Marplan poll conducted in 1988 asked people if they thought that women should have the right to choose an abortion in the first few months of pregnancy. The results showed that 80% agreed that they should, 15% disagreed, and 5% did not know or would not say. The survey showed that even two thirds of Catholics were in favour of the right to choose.[18] Polls reveal consistently that people who vote Conservative are more likely to support abortion rights than those who vote Labour, although it has been the Conservative members of parliament who have most often voted in favour of restrictions.[9 18]

The main focus of recent parliamentary concern has been the time limit for abortion, and here public response has been sensitive to the kind of question asked. When David Alton introduced his bill to reduce the time limit for abortion to 18 weeks' gestation a Marplan poll asked if the present limit on abortions should be reduced to 24 weeks, 18 weeks, or stay at 28 weeks. In reply 15% of people said it should be kept at 28 weeks, 12% said it should be reduced to 24 weeks, 44% said it should be reduced to 18 weeks, and 28% did not know. When a Marplan poll later asked under what circumstances people would agree with an abortion after 20 weeks, however, the results showed a very different picture. A total of 77% supported it if the woman's health was at risk, 67% if the child would be physically handicapped, and 71% if the woman had been raped. A later poll showed that four out of five people would agree with an abortion after 18 weeks if the woman had been diagnosed as carrying HIV.[18]

Travel for abortion

Ever since abortion has been legal in Britain women who could afford the fees and expense have come here from countries with restrictive laws to have their pregnancies terminated. Women even came to Britain from the United States—no fewer than 2487 in the first full year during which the act was implemented. New legislation in New York in 1970 greatly reduced this need, and by 1971 only 254 Americans came to Britain for abortions. The number of foreign women who came to Britain for abortions peaked in 1973, when 56 000 came, of whom 35 500 were French; during this year there were just over 100 000 abortions performed on women living in Britain. When, in 1975, abortion on request in the early stages of pregnancy was legalised in France the numbers of French women coming to Britain for abortions fell rapidly to about a tenth of what they were previously. Their place was taken by Spanish women and a second peak in the number of foreign women occurred in 1983, when 34 800 women from overseas had abortions in Britain (21 000 of them from Spain), but the increasingly liberal interpretation of Spain's new law has led to a drop in the number of Spanish women coming to Britain for an abortion from 22 000 in 1983 to less than 6000 in 1987 and an estimated 3000 in 1988.

Variations in rates of abortion

The rate of abortion per thousand women in England and Wales is 14·8, a moderate figure when compared with other countries (table V) (rates range from 5·6 in The Netherlands to 181 in the Union of Soviet Socialist Republics). Most people believe the contrasts reflect not only attitudes to abortion but also the quality and content of sex education and the provision of contraception.

Discussion

Despite 15 attempts to change the 1967 Abortion Act, three of them involving major debates (White in 1977, Corrie in 1979-80, and Alton in 1988) it has come of age unchanged, and, despite the inadequate facilities for abortions in the NHS, difficulties in access, and reliance on the private sector, which causes hardship for many women, in medical terms it must be judged a success.

Doctors have learnt that early abortion is a safe operation and in most cases has no adverse sequelae, either mental or physical. Most British women who have abortions have, since 1967, been spared the secret burden of shame and guilt that is still carried by women from Northern Ireland who have abortions. Nevertheless, having been the first country in the wave of reform of the abortion law Britain now lags behind many European countries and the United States. The 1967 Abortion Act requires women to obtain the opinions and signatures of two doctors before an abortion is performed. This is far from abortion on request, and it is the youngest and most vulnerable women who are most likely to end up having late abortions because of the difficulties in finding their way through this system.

We believe that the law needs further reform to allow abortion on request in the first trimester, and all district health authorities should be required to provide an adequate service for at least 90% of the need for abortions (based on the average rate of abortion for the country, adjusted for the age structure of their population). Such changes would reduce the number of late abortions, which is said to be the main concern of those who want to reform the 1967 act. The present or any new law should be extended to include Northern Ireland.

Reduction in the need for abortion by improving sex education and provision of contraceptives should be the way forward for the public and the medical profession in the next few years, but last week many women will have thanked David Steel and those who lobbied so hard to change the law in 1967.

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A fund launched in response to Wendy Savage's suspension from her post as consultant obstetrician in Tower Hamlets four years ago raised £60 000 towards her legal expenses. When the Medical Defence Union reversed its original decision and agreed to pay her costs Mrs Savage expressed the wish that the money that was not reclaimed by contributors (most of the total) should go to setting up Womanschoice. This has now been done. The organisation's aims are to educate the public about pregnancy, childbirth, and child rearing, particularly about the choices available, and to promote research into these; it will also promote the provision of related medical care, treatment, and services. Details of the first two projects have been announced. One will entail research by an obstetric registrar into the antenatal experiences of women in Tower Hamlets, the other will be an evaluation of the maternity services liaison scheme, set up in 1981 among Bangladeshis, Vietnamese, and Somali women in Tower Hamlets and since extended.

Further details about Womanschoice may be obtained from three of its trustees: Luke Zander (01 735 8881), Heather Reid (01 980 2829), and Wendy Savage (01 837 7635).

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ANY QUESTIONS

Is the incidence of viral infection in the population rising?

Advances in laboratory technology now make it possible to identify an increasing number of viral pathogens. Thus, during the past 15 years or so, viruses causing hepatitis A and D (delta agent), epidemic non-A, non-B hepatitis, and haemorrhagic fevers have been identified. A parvovirus (B19) has been shown to cause erythema infectiosum and aplastic crises in patients with sickle cell disease; and a new herpes virus (HPV6) has also been discovered. It is unlikely that the incidence of infections with these as well as other viruses has risen in most communities. The increased attention given to them merely reflects our ability to detect viruses, which in turn focuses attention on preventive measures.

Nevertheless, changes in behavioural patterns may result in an increased incidence of some virus infections in particular population groups. Thus, larger numbers of people now travel more often and further afield and may import such infections as hepatitis A, non-A, non-B hepatitis, and occasionally hepatitis B; importations of heamorrhagic fevers such as Lassa fever are fortunately rare. Such retroviruses as human T lymphotropic virus-I, which plays a part in the pathogenesis of adult T cell leukaemia and tropical spastic paraparesis, and human T lymphotropic virus-II, which is associated with the rare hairy cell leukaemia, are now becoming more common among injecting drug abusers in the United States; this needs to be closely monitored elsewhere.

The incidence of HIV (another retrovirus) is increasing dramatically in sub-Saharan Africa, where it spreads principally by the heterosexual route in the general population. As yet in Britain, as well as in many other developed countries, infections with HIV occur most commonly among such high risk groups as male homosexuals, those who travel to and are sexually active in countries with a high prevalence of HIV, and injecting drug abusers. It is in this latter group that HIV, like human T lymphotropic viruses-I and -II, seems to be spreading most rapidly, particularly in parts of southern Europe.

Virus infections, which are often severe, occur frequently among people who are immunocompromised, of whom there are a large number in hospital practice. It is important to identify these infections as many may now be treated.

Despite the increase in viral infections in certain "high risk" population groups, immunisation programmes have resulted in a dramatic fall in viral infections—for example, polio—and even eradication—for example, smallpox. The augmentation of the rubella vaccine programme in Britain in which mumps, measles, and rubella vaccine will be given in infancy is aimed at eradicating these infections. In the United States, where this vaccine has now been used extensively for some years, measles, mumps, and rubella are now rare.

I hope that other infections become less common, particularly in developing countries as a result of the World Health Organisation's expanded programme on immunisation, which aims to immunise all children in the world against several infections including polio and measles by the year 2000.—J E BANATVALA, *professor of virology, London*