Should Abortion Reporting Continue in Canada?

Dawn Fowler, MA, MUP,¹ Konia J. Trouton, MD, CCFP, MPH²

Surgical abortion in Canada has been a recognized medical procedure since removing it from the criminal code in 1969.¹ From 1969 through 1988, Therapeutic Abortion Committees (TAC) were established at each hospital where abortions were performed, and women needed to apply to the TAC in order to have an abortion. In addition to monitoring the decriminalization of abortion, a database was established for annual reporting. In 1988, the Supreme Court decision ruled in favour of abolishing the TACs.² However, the database has not been reviewed and the purpose of abortion monitoring and surveillance today is not clear.

The presumption is that all women in Canada who want an abortion have ease of access to services. In reality, women do not have equal access to abortion services. The purpose of this commentary is to argue for routine, publicly funded monitoring of abortion services, but with the purpose of reporting on compliance with the Canada Health Act (CHA).

Gaps in access

The need for abortion services is high; available statistics show that over one in four pregnancies are resulting in an abortion. If the demand is this high (about 110,000 abortions in Canada per year³), then the question is: "How many women

are not able to obtain an abortion?" Today, we cannot answer this question.

A review of how each provincial and territorial government provides for abortion services shows that the principles of the CHA are being violated. Prince Edward Island provides no abortion services, and does not allow for reciprocal billing for abortion. Abortions are not available before 7 weeks or after 14 weeks in Nunavut, the Northwest Territories or the Yukon because of a lack of trained providers. In northern and remote parts of Newfoundland, Ontario, Quebec, Manitoba, Saskatchewan, Alberta and BC, there are similar problems of lack of service. The need to obtain travel authority in some remote locations leads to unnecessary and dangerous delays. Many women are left to shop around by themselves for services – this compounds the problem, the number of weeks of gestation being a critical factor in having the procedure performed.

Many jurisdictions do not cover the entire cost of abortion services, even though these are available within the jurisdiction. For example, the costs of abortions in hospitals are entirely covered, but those in clinics are incompletely subsidized. In New Brunswick, Nova Scotia and Quebec, there are clinics where neither the physician billings nor the clinic costs are borne by the provincial billing system. In British Columbia and Ontario, there are clinics where only the physician fee is covered.

There is a cap for abortion services in clinics in Alberta, BC and Ontario. This limits the number of abortions per month that can occur at a particular facility, or the number per year that a single provider can perform. Therefore, this creates a bias for women who get pregnant at the beginning of the month, or early in the year.

There are a limited number of trained providers in Canada. Training in abortion is not a mandatory part of family practice or gynecological training. With the other factors that create gaps in access, we cannot understand how this is justifiable.

Gaps in monitoring and reporting

Since 1995, the Canadian Institute for Health Information (CIHI) has collected information on abortions. These data are then sent to Statistics Canada for analysis and publication. Data from 1996 have just recently been published electronically.

The Statistics Canada publication "Therapeutic Abortions 1995" acknowledges that there are inconsistencies in the data.³ Since 1988, a number of hospitals in Quebec and all facilities in BC stopped filling out the therapeutic abortion individual case report form prescribed by Statistics Canada. Currently, some provinces only provide counts, and no information on the medical and demographic items listed. In other provinces, hospitals provide detailed information but clinics report only counts. Therefore, there is detailed information on 76% of all abortions in Canadian hospitals and on 55% of all abortions in clinics. The indicators created from the data currently collected do not adequately address the gaps in access and portability.

Can we standardize appropriate content?

Consultations were undertaken with Canadian participants at the annual National Abortion Federation (NAF) meetings in 1997/98 and with clinics in several cities. It was stated that the existing variable list prescribed by Statistics Canada was inadequate.

A pilot of electronic data collection and a revised variable list was conducted from

1. Consultant in Health Information

2. Assistant Professor, Department of Family Medicine, University of Ottawa

Both Konia Trouton and Dawn Fowler worked in the Bureau of Reproductive and Child Health, LCDC, Health Canada.

Correspondence: Dr. Konia Trouton, Dept. of Family Medicine, University of Ottawa, 43 Bruyère St., Ottawa, ON, K1Y 3Y3

The opinions expressed in this article are those of the authors and do not represent the views of any organization or group.

April 1998 until April 1999 with several clinics and hospitals. The pilot variable list also added other possible determinants of access, e.g., working status, ethnicity, and education.

The most frequent comment from the pilot was that only relevant data should be collected – data needed to monitor compliance with the CHA. Access is denied on the basis of geography and provider availability, not on the basis of factors such as ethnicity, working status, education, past reproductive history or marital status. Therefore, indicators should focus on waiting time, requirement to pay, and location of services, relative to a woman's home.

Another important factor was a high degree of concern for security and confidentiality. The now annual attacks on providers have heightened the need for protection of clinic staff. It was stressed that any data collection activities should respect the confidentiality of both women and providers.

RECOMMENDATIONS

Based on these findings, we recommend the following variables be collected from both clinics (including CLSCs-community health centres) and hospitals:

- 3 digit postal locator of client's residence
- 3 digit postal locator of facility
- If fee is required for service
- Age of women
- Gestational age (proxy for wait time)
- Time (days) from date decision made to date of service

We recommend that the following indicators be reported on:

- Number of therapeutic abortions by province/territory
- Therapeutic abortion rates (per women aged 15-44, and per 100 live births)
- Number of abortions in hospitals compared to clinics
- Teenage abortion rates per women aged 15-19
- Abortion rates in each gestational age category ($\leq 6, 7, 8, 9-12, 13-16, 17-19, \geq 20$)
- Average distance travelled to get abortion by province/territory
- Average wait time by province
- Number of women paying for services

Some family physicians and gynecologists are providing medical abortions as an option for women with a pregnancy less than 7-8 weeks gestation. There is no separate procedure or billing code for a medical abortion, except in BC. The CIHI database is intended only for surgical abortions. Our suggested modifications could be applied to both types of abortion.

CONCLUSION

The issue today is not whether women should have access to abortion. Neither is the issue the safety of abortions as a medical procedure. The issues today are access and portability and the need to ensure that the principles of the CHA are respected. This should be the role of publicly funded national monitoring.

We recommend that CIHI continue to be the data collector, using the modified

list, and from all sites; and that Statistics Canada continue to house the data but prioritize the timely distribution of summary data.

Neither Statistics Canada nor CIHI have joined NAF and therefore do not have the opportunity to meet and discuss with those working in facilities to determine ways to implement this modified list of variables and develop a reporting format. In contrast, the Centers for Disease Control in Atlanta is a NAF member and sends at least one representative to the annual meetings. We suggest that Statistics Canada or CIHI join the network.

REFERENCES

1. Criminal Code, RSC 1970, cC-34, s251.
2. R v. Morgentaler [1988] 1 SCR 30.
3. Statistics Canada. *Therapeutic Abortions, 1995*, Catalogue no. 82-219-XPB.

COMING EVENTS ACTIVITÉS À VENIR

To be assured of publication in the next issue, announcements should be received by **November 15, 2000** and valid as of **December 31, 2000**. Announcements received after **November 15, 2000** will be inserted as time and space permit.

Pour être publiés dans le prochain numéro, les avis doivent parvenir à la rédaction avant le **15 novembre 2000** et être valables à compter du **31 décembre 2000**. Les avis reçus après le **15 novembre 2000** seront insérés si le temps et l'espace le permettent.

Surveillance in Public Health: From Collection to Intervention

2000 Annual APHEO Conference

Hosted by the Association of Public Health

Epidemiologists in Ontario

16-17 November 2000 Oshawa, ON

Contact: Dr. Philippa Holowaty

Durham Region Health Unit

Tel: 905-723-8521 (2234) Fax 905-723-6026

E-mail holowa_p@region.durham.on.ca,

www.cehip.org/APHEO/events/conference2000.htm

Blueprints for the Future: Designing Tomorrow's Home Care, Today!

Canadian HomeCare Association

3-5 December 2000

Calgary, AB

Contact: CHCA Conference: Blueprints for the future
c/o aNd Logistix Inc.

Tel: 416-593-7744

Fax: 416-593-1805

E-mail: CHCA@andlogistix.com

Better Breathing 2001

The Ontario Thoracic Society's annual scientific conference on respiratory health

26-27 January 2001

Toronto, ON

Contact: The Ontario Thoracic Society

573 King Street East, Suite 201

Toronto, ON M5A 4L3

Tel: 416-864-9911

Fax: 416-864-9916

E-mail: julianaq@on.lung.ca

Advances in Qualitative Methods

The Second International Interdisciplinary Conference, sponsored by the International Institute for Qualitative Methodology and the University of Alberta

22-24 February 2001

Edmonton, AB

Contact: Dr. Janice Morse

International Institute for Qualitative Methodology

Tel: 780-492-5914 Fax: 780-492-9040

E-mail: qualitative.institute@ualberta.ca

www.ualberta.ca/~iiqm/methods01.html

CALL FOR ABSTRACTS

The 17th Congress of the International Association of Gerontology

Global Aging: Working Together in a Changing World

1-6 July 2001

Vancouver, BC

Contact: Congress Secretariat

Gerontology Research Centre, SFU

Tel: 604-291-5062 Fax: 604-291-5066

E-mail: iag_congress@sfu.ca

www.harbour.sfu.ca/iag/

Deadline for submission of abstracts:

31 December 2000