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U.S. Abortion Rate Continues to Decline While Debate over Means to the End Escalates

By Joerg Dreweke

When the Guttmacher Institute released a study in February finding that the U.S. abortion rate had declined 13% between 2008 and 2011, and had reached its lowest level since 1973,[1] intense debate quickly followed over the responsible factors. The study's authors hypothesize that improvements in contraceptive use—in particular, a shift to highly effective methods—were a main contributing factor. By contrast, opponents of abortion rights dismiss contraception as playing a role. Instead, they point to state-level abortion restrictions and a growing "culture of life" that are compelling women to carry unwanted pregnancies to term rather than obtain abortions.[2]

This debate exposes the widening gulf between antiabortion and prochoice advocates over whether society should strive to reduce abortion—at all costs—or focus instead on reducing the need for it. Vastly different policy agendas derive from these two divergent goals. The U.S. antiabortion movement has relentlessly pursued a strategy of making abortion care unattainable for growing numbers of women by enacting progressively harsher legal barriers to services at the federal and, especially, state levels—with the goal of eventually criminalizing abortion nationwide. By contrast, most abortion rights supporters believe that reducing the need for and, thereby, the incidence of abortion is an important goal. But they are firm that this must begin with helping women better prevent unintended pregnancy in the first place by providing greater access to the full range of information and services that women need, while keeping abortion legal and accessible.

Paradoxically, the philosophical divide over the "means" to make abortion rare—restricting women's choices versus supporting and expanding them—has grown more contentious at the same time that more progress has been made than at any point in four decades toward achieving the "end." With not only abortion rights on the line, but increasingly also the means to prevent the unplanned pregnancies that lead to abortion, the stakes for women have never been higher.

Historically Low Levels

The Guttmacher study released earlier this year reports that both the rate and the number of U.S. abortions had declined by 13% between 2008 and 2011, and that the abortion rate had reached its lowest level since 1973 (see chart).[1] Although the study was not designed to pinpoint reasons behind the 2008–2011 drop in abortion, it examined a number of possible factors and ultimately built a strong circumstantial case that changes in contraceptive use—rather than state restrictions—most likely had played a key role.

The Role of State Restrictions

States enacted 205 abortion restrictions between 2011 and 2013, more than in the entire previous decade combined,[3] and antiabortion activists were quick to jump on this wave of restrictions as the reason for the reported decline in abortion. For instance, the group Americans United for Life wrote in a blog post about the drop in abortion incidence that "what is compelling about this report can be seen on the front page of the Guttmacher Institute website, where they note the record number of new pro-life laws on the book, while they claim…that these measures

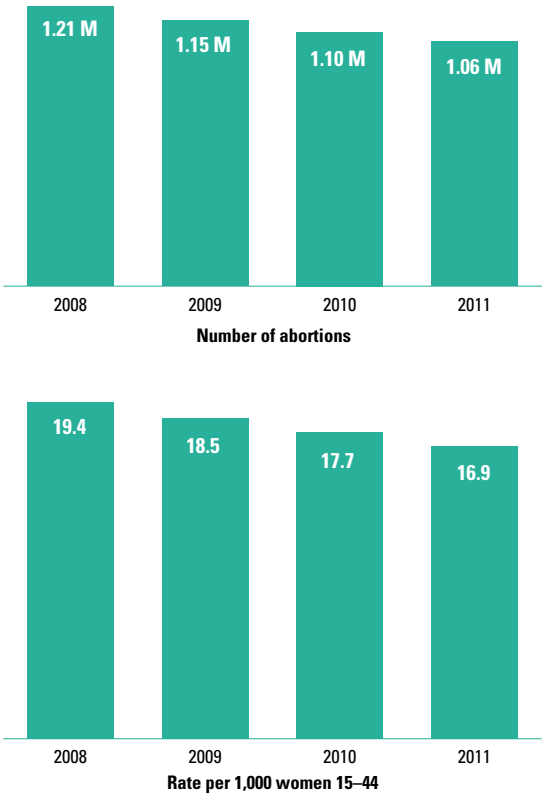
have no impact."[4] However, the period covered by the abortion incidence study (2008–2011) predates the surge in restrictions (2011–2013), and even most restrictions enacted in 2011 did not go into effect until late that year. Furthermore, between 2008 and 2011, the number of abortion providers declined by only 4% and the number of clinics (which provide the large majority of abortion services) by just 1%.[1] This suggests that reduced access to abortion services—a potential consequence of state restrictions—does not explain the decline in abortion.

An additional indication that state laws are likely not driving the drop in the abortion rate is that the rate declined in all but six states between 2008 and 2011, including those that place few if any restrictions on abortion access, such as California, New Jersey and New York. Some restrictions, such as the 2009 in-person counseling requirement added to the existing 24-hour waiting period in Missouri, may have posed a barrier to service for some women who could not make the additional visit, thereby potentially reducing incidence. However, these isolated examples were far from sufficient to explain the significant drop that spanned almost all states and every major region of the country.

Finally, the decline in abortion between 2008 and 2011 coincided with a steep national drop in the birthrate (9%).[1] If restrictions in fact forced large numbers of women with unplanned pregnancies to give birth instead of obtain an abortion, one would expect to see births replacing abortions—resulting in a corresponding increase in the birthrate. The same would hold true if, as part of a growing "culture of life," more women with unplanned pregnancies decided on their own accord to carry their pregnancies to term. But births appear not to have been replacing abortions to any significant extent during the period, as the abortion ratio—that is, the number of abortions for every 100 pregnancies—declined only slightly between 2008 and 2011, from 23 to 21. By looking at abortion and birth numbers, this point becomes even more clear: Between 2008 and 2011, abortions declined by about 150,000,[1] but births by roughly twice as much (down about 300,000).[5,6]

ON THE DECLINE

The rate and number of U.S. abortions dropped substantially between 2008 and 2011, continuing decades-long declines.



Source: reference 1.

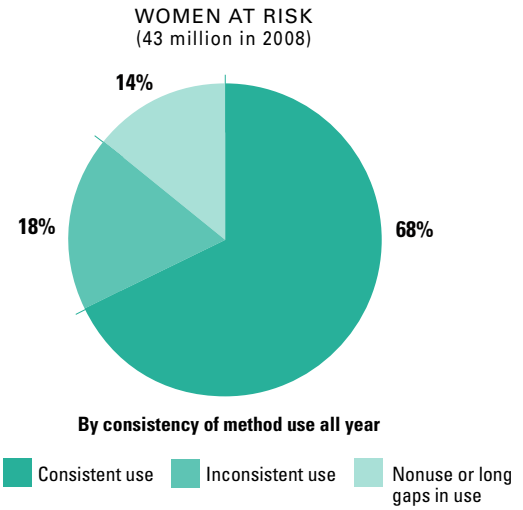
The Role of Contraception

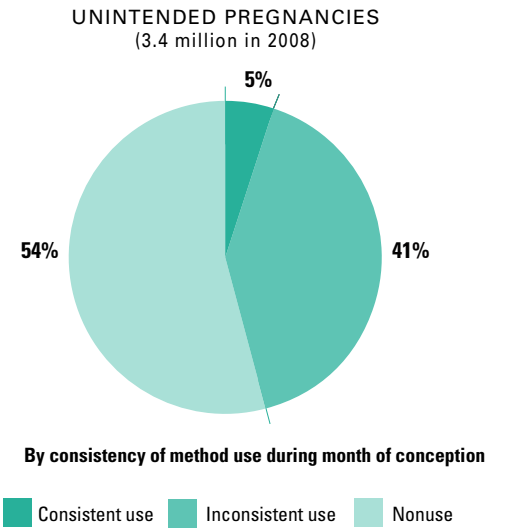
The simultaneous drops in abortions and births between 2008 and 2011 amount to an overall decline in the number of pregnancies during this period and point to improved contraceptive use as the most likely explanation. Under this theory, a combination of increased contraceptive use and greater reliance on highly effective methods helped reduce overall levels of unintended pregnancy and subsequent abortion. Although data on contraceptive use and unintended pregnancy are not available yet for the entire study period, several trends buttress this theory.

First, between 2007 and 2009, the proportion of women younger than 30 who were at risk of unintended pregnancy but not using any method of contraception dropped by one-fifth, from 15% to 12% (a statistically significant change).[7] Not

CONSISTENT USE IS KEY

The two-thirds of women who practice contraception consistently all year account for only 5% of unintended pregnancies.





Notes: "Nonuse" includes women who were sexually active, but did not use any method of contraception. "Long gaps in use" includes women who did use a contraceptive during the year, but had gaps in use of a month or longer when they were sexually active. "Inconsistent use" includes women who used a method in all months that they were sexually active, but missed taking some pills, or skipped use or incorrectly used their barrier method or condom during some acts of intercourse. "Consistent use" includes women without any gaps in use who used their method consistently and correctly during all months when they were sexually active, including those who used a long-acting or permanent method. *Source*: reference 8.

only are women in this age-group traditionally at high risk of unintended pregnancy, but research also shows that among all women at risk of unintended pregnancy, the small proportion not using contraception (14%) account for more than half of all unintended pregnancies (54%; see chart).[8] Even the seemingly small shift away from contraceptive nonuse among women younger than 30 could therefore have a measurable impact on national levels of unintended pregnancy and abortion.

Another factor is the potential impact of shifts in the contraceptive method mix toward highly effective methods, such as the IUD and the implant. Women weigh many factors in their choice of methods, but long-acting, reversible contraceptive (LARC) methods have several important strengths: They are more than 99% effective at preventing pregnancy, last 3–12 years and do not require women to remember to use their method every day or every time they have sex. The shift to methods that virtually guarantee consistent use is critical, given that the more than two-thirds of women (68%) who use contraception consistently and correctly over the course of a year account for only 5% of unintended pregnancies.[8] Consequently, even relatively modest increases in LARC use could affect abortion rates. Contraceptive usage trends, even without data for the most recent years, support this theory. In 2002, only 2.4% of contraceptive users relied on LARC methods; however, this proportion rose to 3.7% in 2007 and then more than doubled within just two years, to 8.5% by 2009.[7] If LARC use continued to increase beyond 2009, it could help explain the national decline in abortion incidence.

Finally, the pregnancy, birth and abortion rates among teens all dropped to record lows between 2008 and 2010,[9] similar to the broader trend observed among all women. Here, too, improved contraceptive use and greater reliance on LARC methods appear to have been the main drivers, especially among older teens (those aged 18–19), who experienced fewer pregnancies, births and abortions, even as an increasing proportion of them reported having sex.

Restrictions Do Matter

State-level restrictions may not have been a main driver of the 2008–2011 abortion decline, but such laws often have a real impact on women seeking abortion care. Research shows that most restrictions do not keep significant numbers of women from obtaining abortions, yet also suggests that the most coercive and burdensome restrictions can have a measurable impact on abortion rates. The strongest available evidence showing such an impact concerns the 1976 Hyde Amendment, which—with very limited exceptions—bans abortion coverage under Medicaid. A comprehensive 2009 Guttmacher literature review, often cited by antiabortion advocates, concluded that one in four women subject to this restriction is unable to obtain an abortion.[10]

Still, not only do most poor women affected by Hyde manage to obtain an abortion, women more generally have long shown that they will endure significant hardship for themselves and their family to navigate and overcome the myriad restrictions states have thrown up in front of them. Owing to women's determination to obtain the abortions they want and need, studies assessing the impact of other abortion restrictions, such as parental involvement laws and mandatory counseling and waiting period requirements, have found either no effect on abortion incidence or at most a very modest one.[11,12] However, this research too shows that coercive restrictions that significantly increase the economic cost of obtaining an abortion—such as by requiring women to make two separate trips to an abortion provider—can have a measurable impact. For instance, multiple studies of such a law in Mississippi have found that the requirement for two separate trips was associated with a decline in the state's abortion rate (although that decline was partially offset by an increase in the number of residents going out of state for an abortion) and delays in accessing abortion services.[12]

The toll of navigating restrictions can be steep, especially for women who are low-income, young or otherwise disadvantaged. Women will often divert money meant for rent, groceries or utilities to pay for the procedure.[13] In addition, women often have to take unpaid time off of work and arrange for child care, transportation and even lodging. Overcoming these financial and logistical hurdles often forces them to wait longer to obtain their abortion, which not only takes an emotional and financial toll, but also increases both the cost and risk (although small at any point) of an abortion.

The lesson from these studies has not been lost on abortion foes: Only those restrictions that raise the economic cost of having an abortion beyond what some women can bear are likely to have a measurable impact on incidence. As one leading antiabortion researcher put it in 2012 when discussing abortion restrictions, "Require the woman to see an ultrasound, or require two trips to the clinic. That raises the costs; that stops the abortion from happening."[14] The same researcher also noted that a two-visit requirement especially impacts women living in rural areas and those who otherwise have to travel long distances to reach an abortion provider. Antiabortion activists are rarely so explicit about stating that their goal is to directly impede women's access to abortion care, as opposed to purporting to protect women's health (see "TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price," Spring 2013, and "All That's Old Is New Again: The Long Campaign to Persuade Women to Forego Abortion," Spring 2009).

Indeed, antiabortion activists and their allies in state legislatures in recent years have embarked on a concerted effort to raise the economic cost of obtaining an abortion for significant numbers of U.S. women—pushing the U.S. abortion debate into uncharted territory. More than 200 state-level provisions restricting access to abortion care were enacted in 2011–2013, with another 17 restrictions added by May 15, 2014. It is not just the sheer number of restrictions that is unprecedented, but also their often extreme and coercive nature (see "A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs," Winter 2014).

Three factors in particular speak to the severity of this new wave of abortion restrictions. One is the frontal assault on availability of services through

the targeted regulation of abortion providers (TRAP laws), which has already forced numerous clinics to shut down and often results in women having to travel much longer distances to access services. Another is the cumulative impact of multiple restrictions in some states, which creates ever higher and more costly hurdles women must clear before being able to obtain an abortion. And the third is the regional clustering of restrictions, especially in the South and Midwest, which makes it extremely difficult for women to obtain needed abortion care in neighboring or nearby states if they are unable to access services in their own state. The use of coercive laws in these ways to raise the economic cost of an abortion and force women to carry an unwanted pregnancy to term may well have a measurable impact on abortion incidence going forward.

It is noteworthy that even as they work to restrict access to abortion care, leading U.S. antiabortion organizations and their political allies have essentially no agenda to help women avoid unintended pregnancy in the first place. Their positions on contraception range from outright hostility to, at best, proclaimed neutrality, and their political allies have slashed—or attempted to do so—funding for family planning services (see "Besieged Family Planning Network Plays Pivotal Role," Winter 2013). Their pregnancy prevention agenda, if any, is generally limited to promoting abstinence outside of marriage and periodic abstinence within marriage, including via discredited abstinence-only programs that withhold information about the benefits of contraceptive use.

The Supportive Framework

In stark contrast to trying to coerce women's reproductive decision making by restricting access to services, reproductive rights advocates have long pushed for policies grounded in voluntarism and informed consent that support all of a woman's pregnancy decisions. These include promoting affordable, high-quality contraceptive information and care to prevent unintended pregnancy; helping women with planned and unplanned pregnancies alike to achieve healthy pregnancies and to raise their children with dignity; and improving access to safe, affordable and timely abortion care in the event of an unwanted pregnancy.

A cornerstone among policies strongly backed by reproductive health advocates is the protection and expansion of publicly funded family planning services provided through programs like Title X and Medicaid. The stellar track record of these programs in reducing unintended pregnancy and abortion incidence is well documented: Publicly supported contraceptive care enables women to avoid 2.2 million unintended pregnancies each year, 760,000 of which would have ended in an abortion.[15] Absent these services, U.S. rates of unintended pregnancy and abortion would be two-thirds higher than they are.

The advent of the Affordable Care Act (ACA), another law backed by reproductive health advocates, likewise could further reduce the incidence of abortion as it greatly expands Americans' access to private and public insurance coverage in general and to contraceptive coverage in particular. A crucial ACA provision (currently subject to numerous legal challenges, including several that have reached the U.S. Supreme Court) requires most private insurance plans to cover the full range of contraceptive methods without patients' having to pay out-of-pocket costs, such as copayments and deductibles. The policy thus guarantees women access to not just any method of contraception, but to the one most suitable for their individual needs and circumstances without cost posing a barrier (see "Contraceptive Coverage at the U.S. Supreme Court: Countering the Rhetoric with Evidence," Winter 2014).

In addition, reproductive health advocates have long worked to expand access to information and services in a variety of other ways. This includes ensuring that teens have access to comprehensive and medically accurate sex education that empowers them both to delay sex and to have the skills they need to protect themselves once they become sexually active. It also includes advocating for a range of pregnancy-related reforms implemented under the ACA, such as provisions prohibiting insurers from regarding pregnancy as a preexisting condition, requiring private health plans to cover maternity coverage and supporting breastfeeding, among others.

Culture Clash

The philosophical divide over what constitutes effective and acceptable ways to further reduce the incidence of abortion in the United States has never been more stark. The rival policy approaches—one centered almost entirely on restricting women's choices, and the other on supporting and expanding them—have now become mutually exclusive. Better and more contraceptive use appears to have been the main driver of the most recent decline in U.S. abortion and is likely to be a key factor in future declines, provided that foes of reproductive rights fail to thwart or further undermine existing policies and programs that promote information about and affordable access to contraception. However, the torrent of coercive state abortion restrictions that have been enacted will very likely result in more women being prevented from obtaining safe and legal abortion services.

Abortion opponents may try to cloak their policies in prowoman rhetoric, but the simple fact remains that these laws are intended to push reproductive decision making in one direction: toward pregnancy and childbearing. Viewed this way, the question is not whether coercive approaches "work" in reducing abortion incidence. Rather, these coercive approaches are unacceptable in principle.

U.S. women and couples have been increasingly successful at achieving their goal of having small families, and they increasingly are doing so without relying on abortion. Even with abortion services legal and accessible to women who need them, abortion can become more rare—for all the right reasons. **www.guttmacher.org**

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