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The Demographic Impact of Legally Induced Abortion after 40 Years in Great Britain

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ABSTRACT The 1967 Abortion Act took effect in Great Britain in April 1968. It has opened the way for legally induced abortions on a larger scale than anticipated. After 40 Years it is possible to draw on the accumulation of British data to make some assessment of the impact in quantitative terms. The fortieth anniversary of the 1967 Abortion Act in Great Britain is also an opportunity to take stock of what has been the impact on society of legally induced abortions.

THE CHALLENGE

British Abortion Statistics (Abortion Statistics) since 1968 are unusually comprehensive and detailed by international standards. In broad terms, the increase in abortions and decline in live births over this epoch are clear enough. We have age specific data on both abortions and live births and can therefore compute for successive birth cohorts of women the cumulated rates. But little research has been done to investigate the social and demographic implications of these abortions nor to assess the impact on the health of women, in the short or long term.

Considerations of privacy and confidentiality weigh against research on abortion. Many private and NHS funded abortions take place in private clinics with anonymity guaranteed. Abortion is not linked in to longitudinal studies. Researchers, who have made attempts to address the issue, have found that abortion is a subject that women prefer not to discuss, at least in official or research contexts. Where abortion might be examined as a relevant factor in a medical study, researchers may prefer not to include any question on abortion in the questionnaire so as not to jeopardise the response.

Investigation of health issues, where abortion is known to be a possible risk factor, is not directed to examining the effects of induced abortions. We can only guess how many of the large numbers of women taking anti-depressant prescribed drugs have a history of induced abortion. It is known that unmarried English women have a higher rate of premature births (Bakeo and Lynda 2006) and that this risk is increased post abortion (Moreau C et al. 2005). In England there has been no study to investigate the unmarried women with premature births to determine to what extent this is due to the higher abortion rate among them or to other factors such as a higher incidence of smoking or to a higher rate of pelvic inflammatory disease etc. Epidemiologists report the major trends in breast cancer (Cancer Statistics). The incidence has greatly increased. There is also a remarkable social gradient whereby upper class women in England have much more breast cancer than lower class women. But these trends are not explained other than in broad terms of modern lifestyle. The contributory effects of abortion and other known risk factors are not separately identified or quantified.

On the other hand, it is known that most British abortions are nulliparous i.e. women having abortions have not previously had any full term pregnancies (Abortion Statistics, Carroll 2007a). Such abortions are thought to be more harmful to health. If most women having abortions have already given birth to all the children they want there would be less reason for concern at difficulties in post abortion pregnancies. But in Great Britain, on the contrary, there is additional reason to be concerned at the health damaging effects of British abortions.

Where the results are clear such as when abortion contributes to the decline of fertility, the professional demographers seem to be the last to acknowledge this (Carroll 2007b). Official population projections in the 1980s and 1990s assumed a recovery in the birth rate would take place to reach replacement level (Population

Projections. Government Actuary's Department, Carroll 2007b). It was claimed that modern fertility control, contraception and abortion, would enable women to have the children they wanted to have. In the UK most abortions are paid for by the state within the National Health Service, while prescribed contraceptives are promoted and paid for in full. The results of this biased policy in lowering the birth rate are not recognised.

THE DEMOGRAPHIC IMPACT

There is no mistaking now that abortion numbers did increase rapidly after liberalisation of the law. Figure 1 for England and Wales shows the increase in numbers was rapid in the early years. Even in recent years there continues to be some increase. Newer fertility control methods, such as emergency contraceptives, are intended to reduce the numbers of medical and surgical abortions but have not had this effect. When 13,443 Scottish abortions are added to 193,737 carried out on English resident women we have a total of more than 207,000 British abortions in 2006.

There has been a corresponding decline in the birth rate, measured by the TFR (Total Fertility Rate) as shown in Figure 2. A few years after the 1967 Act the TFR dropped below replacement level. The TAR (Total Abortion Rate) can be calculated in the same way as the TFR. For most of this epoch the TAR has closely matched the shortfall of the TFR below replacement level. But now in 2006 the total of TFR 1.86 and TAR 0.55 is rather more than replacement 2.07. There have been recent increases in the TAR following promotion of emergency contraceptives ("morning-after pills"), which were intended to avert induced abortions without achieving this desired effect, and an increase in the TFR that is partly explicable by the presence of immigrant groups here with a higher birth rate.

The decline in fertility is of course also closely linked to the introduction of hormonal contraceptives. Sex education has promoted the use of contraception. Marital status is a further influence on fertility. Single parent families tend to be smaller, especially where the parents have never married; single women have a higher abortion rate than married women.

For a full explanation of fertility decline in the UK (Assessing the Damage, Carroll 2007a, b) socio-economic changes also need to be considered. Improved educational and professional opportunities for women have made childrearing less attractive. Other factors tending to lower fertility include privatisation of social housing that has exposed more young couples on moderate incomes to the financial strains of house purchase and mortgages.

In a report (Assessing the Damage, Carroll 2007a) produced to mark the 40 Years anniversary of the 1967 Abortion Act, this decline in fertility is discussed in more detail and estimates made of what the population might now be were it not for legally induced abortions. The impact on social security funding is also considered. An ageing population faces a greater burden of pension costs falling on a smaller population of working age, notwithstanding the planned increases in state pension age taking effect.

The pattern of parous and nulliparous abortions since 1968 is shown in Figure 3.

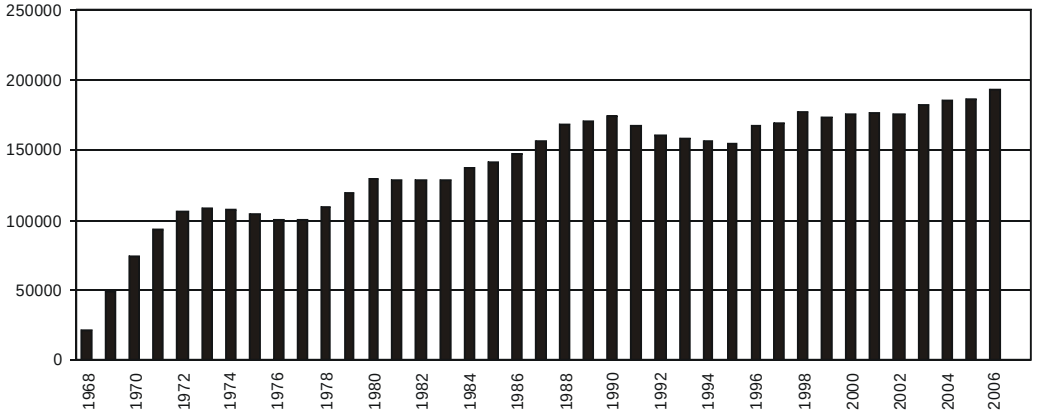

Fig. 1. Number of legally induced abortions. Resident women England and Wales 1968-2006

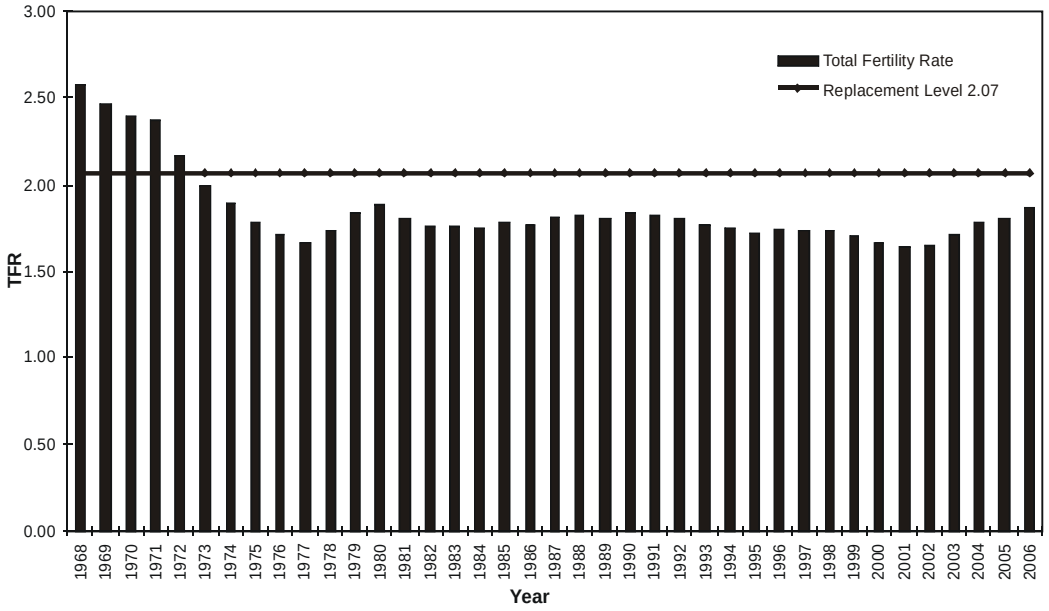

Fig. 2. Total Fertility Rate (TFR) for England and Wales, 1968-2006

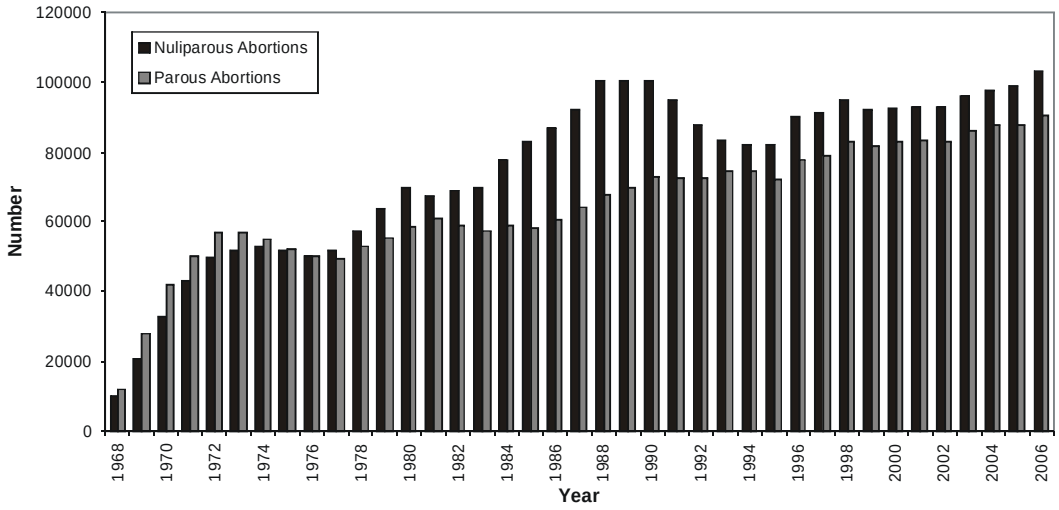

Fig. 3. Number of parous and nulli parous abortions of women in England and Wales 1968-2006

Nulliparous abortions increased rapidly until 1990. But the recent increases in abortions are mostly parous abortions. Since 1990 that parous have increased faster than nulliparous – both in number and percentage. This can be understood as a reflection of the increase in single parenting. Many first births are now outside wedlock. Single parents choose abortions so as not to add to their families. Abortion rates continue to be much lower among married women. (Abortion Statistics).

Abortion Complications and Difficulties in Pregnancy post Abortion

Most British abortions (53% in 2006) continue to be nulliparous. Infertility and impairments to

fertility post abortion are real problems when women have not yet given birth to any live born children. In the UK the increase in infections, which can cause infertility, such as Chlamydia that are Pelvic Inflammatory Diseases and also Sexually Transmitted pose an additional threat to post abortion fertility. The results of testing for Chlamydia are not usually available at the time of an abortion. Rapid discharge after all operations including abortions is now a goal for better management of health resources. Fewer complications are now reported within abortion clinics. (Abortion Statistics) We can only guess at what further increases in infertility, premature births, low weight births and ectopic pregnancies are to be expected.

Mental Health

Mental illness post abortion is usually classed in the depression range. Many more women are now prescribed anti-depression treatments; 31 million prescriptions of this kind in 2006 are thought to have been mostly dispensed in England for women, of an age where they might have had abortions (Prescription Statistics).

Breast Cancer

British abortions are more carcinogenic as most of them are nulliparous. Nearly all of the nulliparous woman's breast lobules (tissue consisting of a milk duct and milk-producing glands) include immature, cancer-susceptible Type 1 and 2 lobules where ductal and lobular cancers develop. During a normal pregnancy, the breasts grow under the influence of elevated levels of the hormones, oestradiol and progesterone, thereby causing her lobules to multiply. If she has an abortion or a premature birth before 32 weeks of pregnancy, she will be left with more places for cancers to start in her breasts.

However, in the last months of a full term pregnancy, the pheromones hCG (human chorionic gonadotropin) and hPL (human placental lactogen) - produced by the fetus - help mature 85% of the lobules into cancer-resistant Type 4 lobules that contain colostrum, thereby leaving her with more cancer-resistant lobules than she had before she became pregnant. That accounts for the known protective effect of a full term pregnancy (Lanfranchi 2008).

The breast cancer risk post abortion is more long term. The average age at diagnosis of malignant breast cancer is over 60 (Cancer Statistics). Of the known risk factors abortion is found to be the best predictor of modern breast cancer trends (Carroll 2007c). Figure 4 compares the cumulated cohort abortion rate for female birth

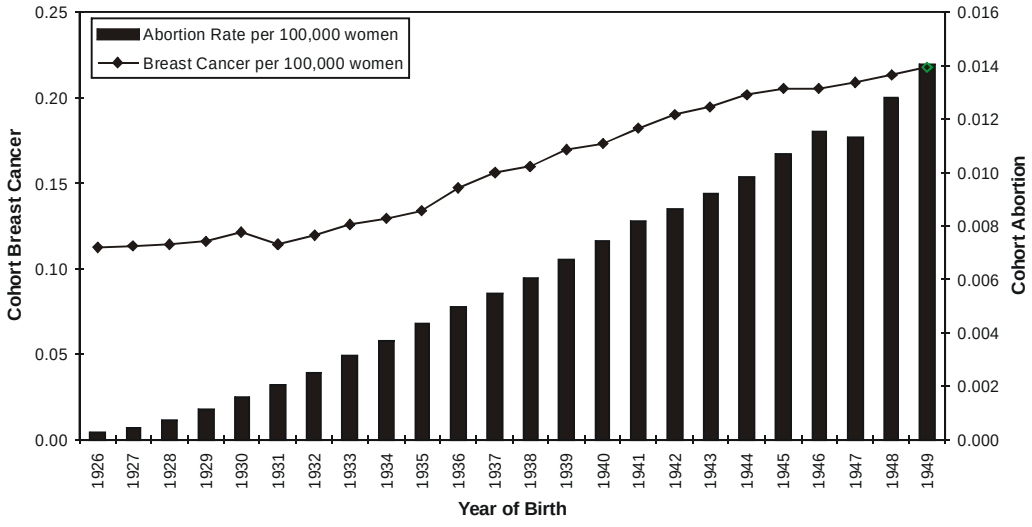

Fig. 4. Cohorts defined by year of birth: Women in England & Wales. Cohort Breast Cancer incidence within age 50-54 ys. Cumulated Cohort Abortions Rate

cohorts in England with the cumulated rate of breast cancer within ages 50-54. The correlation coefficient >0.9.

British abortions are more carcinogenic as most of them are nulliparous, leaving breast cells in a state of interrupted hormonal development where they are more susceptible to cancer. reference.

The social gradient for female breast cancer is unlike that of other cancers. There is a reverse or negative social gradient, whereby upper class women have the higher incidence. In England this gradient is particularly steep, but there is no official explanation for it. Women with higher educational and professional opportunities are known to delay childbearing. This implies a later age at first birth, known to cause some increase in breast cancer risks in later life, not enough in itself to explain the British social gradient. But it also implies a higher nulliparous abortion rate which could help to explain the steep British social gradient for breast cancer (Carroll 2007c).

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