Winter 1988

Abortion policy implementation: Understanding the availability of abortion services in the United States

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Order Number 8907439

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University of New Hampshire, 1988

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ABORTION POLICY IMPLEMENTATION: UNDERSTANDING THE AVAILABILITY OF ABORTION SERVICES IN THE UNITED STATES

BY

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DISSERTATION

Submitted to the University of New Hampshire
In Partial Fulfillment of
the Requirements for the Degree of

Doctor of Philosophy

in

Sociology

December, 1988

This dissertation has been examined and approved.

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8/17/88
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In Memory of Elizabeth Marie Berliss Sanger

ACKNOWLEDGEMENTS

I would like to thank my committee members who have made important contributions to this study. Professors Murray Straus and Arnold Linsky have been constant support and guidance throughout the revisions of this research. Professors Betty Roberts and Raelene Shippee-Rice provided wonderful encouragement and enthusiasm for my approach to the study of policy implementation. I express my deepest appreciation to my advisor, Professor Sally K. Ward. Her criticisms, insights and encouragement have been of highest value.

From the inception of this project to its completion members of the Family Research Laboratory with whom I work have been patient and accepting. Special recognition to Benjamin Badger for his inquisitive nature, and his quick and precise job in formatting and typing the tables and figures. I also thank family members and my friends who were dependable sources of support over the years; especially my friend Kim Vogt who was always available for advice and direction. Special acknowledgement to Don Markley for whom "[F]air, Kind and Truth is all my argument" (Shakespeare, Sonnet 105). Finally, I want to thank Dr. Anne Lawing, who brought merriment to this task.

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ABSTRACT

ABORTION POLICY IMPLEMENTATION:
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This study examines five factors predicted to be related to abortion, and assesses their influence on the availability and use of abortion services. A policy implementation framework is used to explore, conceptualize and analyze the extent to which these factors may have important effects on abortion services. Availability and use of abortion services are viewed as measures of the implementation of the 1973 Supreme Court rulings on abortion. State level data are used to investigate the extent to which the predicted factors influence abortion services.

This study reveals that many factors associated with the issue of abortion work together to influence abortion policy implementation.

It demonstrates that availability and use of abortion services are conceptually distinct measures of policy implementation, and that the demand for abortion is separate from how readily services are available. Availability is affected by differing views concerning the family, economic status of women, pressures of social movements and availability of physicians. Use of abortion services is affected by the social and political climate primarily through availability of abortion providers, along with existing characteristics of the health care system and with the level of demand for abortion. In order to increase the availability of abortion services, it is recommended that the social and political climate of a community be assessed in conjunction with the limitations associated with the availability of health care services.

CHAPTER 1

INTRODUCTION

Abortion has never been a neutral issue. The subject of abortion has few equals as an emotionally charged public policy issue. But, the subject has yet to attract a proportionate degree of interest on the part of social science research. This research is an effort in that direction. It investigates responses to the enactment of abortion policy and the consequences of these responses for the availability of abortion services.

Abortion policy is defined by the 1973 Supreme Court rulings on two abortion cases: Roe v. Wade and Doe v. Bolton. The Court's decision in Roe v. Wade recognized that the right of privacy was broad enough to encompass a woman's decision whether or not to terminate her pregnancy; and the Doe v. Bolton decision struck down several state abortion requirements. In essence, the Supreme Court ruled abortion legal during the first three months of pregnancy

> "For the first three months of pregnancy the decision to have or not to have an abortion lies with a woman and her doctor, and the state's interest in her welfare is not 'compelling' enough to warrant any interference" (The New York Times, Jan. 23, 1973, p.1).

The Supreme Court Decision as Abortion Policy

The 1973 Supreme Court rulings on the two abortion cases established a policy which a) recognized the right of women to terminate a pregnancy, and b) "[E]rected a constitutional barrier to governmental prohibitions on abortion in the first trimester of

pregnancy" (Carter 1977, p. 141). Considerable debate exists as to whether the Supreme Court is a policy making institution. The conservative viewpoint is that the function of the Supreme Court is 'merely' to interpret the written constitution. From another perspective, the Supreme Court does more than 'merely' interpret the written law. The rulings or decisions made by the Supreme Court amplify the meaning of the law, which in turn legitimates social behavior (Carter 1977; Tatalovich & Daynes 1984). Horowitz (1977) has effectively argued that the nature of the judicial decision-making has fundamentally changed. Traditionally, the highest court resolved grievances. Today, the Supreme Court is engaged in problem-solving, especially with constitutional questions of civil liberties and civil rights. Several legal scholars have suggested that the Supreme Court's "intervention in social policies was legitimated by the school desegregation cases - beginning with Brown v. Education" in 1954 (Tatalovich & Daynes 1984, p. 211). Brown v. Education prohibited segregation in public schools. The decision, in effect, changed our schools and our ideas about racial justice and racial policy (Carter 1977).

Court decisions frequently require fundamental changes in established practices. Judicial rulings often displace the judgment of elected officials, especially in such areas as education, civil rights, and abortion. Judges interpret the constitution and therefore make decisions that directly affect large numbers of people and indirectly affect us all (Carter 1977). It is the view of this researcher that policy refers to any authoritative decision or

intervention whose action has an affect on the welfare if citizens by providing services or income, or is designed to affect the structure of social norms, social relations or social decision-making. Based on this definition of policy, decisions by the Supreme Court can be seen as policy decisions. In terms of abortion policy, the enactment of the Supreme Court decision involved the use of authority "to modify or replace social values, institutional practices, and norms of interpersonal behavior with new modes of conduct based on legal proscriptions" (Tatalovich & Daynes 1984, p. 208). As mentioned earlier, viewing the Supreme Court as a policy-maker is unusual but nor without precedent. This research is not an investigation of the Supreme Court and the forces involved in making policy. Rather, the focus of this investigation is on the implementation of abortion policy. The 1973 Supreme Court decisions on abortion serve as the background and foundation for conceptualizing factors which may have important effects on abortion services.

Implementation of the Supreme Court Decision

Implementation of the Supreme Court decision can be reflected in the availability and use of abortion services. Given this understanding of abortion policy implementation, it can be seen that the implementation of the Supreme Court decisions has a significant impact on all women. Reproductive decisions shape all aspects of women's lives. From a feminist point of view, legalization of abortion has a positive effect on the life choices available to all women. The Supreme Court ruling stated that a woman's decision to terminate an unwanted pregnancy was between her and her physician.

One effect of this landmark decision was to make the practice of abortion legal, and in effect guarantee women the right to safe abortions. Another major effect of legalization "was to make abortion a 'safe and legal' medical practice" (Petchesky 1984, p. 156). Although Roe v. Wade rapidly made medical provision legal across the United States, the judicial ruling did not require the provision of abortion services. In other words, the Supreme Court recognized the legal right to obtain abortion by prohibiting states from limiting services, but the Court did not require states or health care networks to provide abortion services (Bond & Johnson 1982). Thus, even after abortion became legal, abortion services did not become widely available. Surveys conducted by the Alan Guttmacher Institute showed that after substantial gains in the number of abortion services, "the extension of abortion services to previously unserved areas [has] proceeded at a slow pace" (Henshaw, Forrest, Sullivan & Tietze 1983, p. 4-5). Since 1976 it has been reported that many women in need of abortions have been unable to obtain them "primarily because such services were unavailable in their home or nearby communities" (Forrest, Tietze, & Sullivan 1978, p. 271). In essence, the Supreme Court decision has not been implemented in all locations, and therefore services are not equally available or not available at all to some groups and classes.

This study explores state level differences in availability of abortion services. The subject of abortion "encompasses a complex set of issues, involving all the intricacies of large scale social change, technological innovation and changing patterns of social life"

(Solomon 1977, p. 163). Characteristics of the state, combined with the social and political controversy surrounding abortion may have important effects on the availability of abortion services. The extent to which this is true is an empirical question, and one that is examined in this dissertation.

OBJECTIVES OF PROPOSED RESEARCH

Investigation of factors affecting the availability of abortion services is a study of policy implementation. One objective is to review the policy implementation literature and develop a framework for a sociological analysis of implementation. Actions of social policy frequently produce both foreseen and unforeseen consequences. Foreseen consequences refer to outcomes or reactions by organizations directly involved with the implementation of the policy. The intentions of these organizations are to influence the goals or purposes of the stated policy. For instance, one of the goals of the Supreme Court decision was to assure women the right to safe, legal abortions during the first trimester of pregnancy. Soon after the Supreme Court decision efforts were launched to deter the availability of abortion services. The direct efforts at restricting abortion are examples of foreseen consequences. However, policies affect and change individuals and institutions other than those directly involved in the policy making process. These social changes may be manifested in the unforeseen and unintended arrangements that arise and influence

the implementation of a decision. These unsought consequences often constrain future action (Whitt 1982). The idea that policy changes can have far reaching effects which can be influential suggests that the unforeseen consequences of a social policy may affect its implementation. It is suggested that the contributions of a sociological analysis to the field of implementation are found in the study of foreseen and unforeseen consequences of policies. In this context, the term 'consequence' refers to various responses to the judicial rulings and explanations of the abortion debate since the 1973 Supreme Court decision and their effects on the availability of abortion services. Some reactions were unintended (unforeseen consequences), and others were intended to influence abortion services (foreseen consequences).

Abortion policy will serve as a case study to assess the utility of foreseen and unforeseen consequences for facilitating a sociological analysis of implementation. The second objective is to build and test a theoretical model of abortion policy implementation. This model will test several responses and explanations of the current abortion debate, and answer the question what social and political structures and values influence the implementation of abortion policy. Creating this model involves conceptualizing the various factors that would affect the availability of abortion services and measuring them. The variables to be studied can be grouped into five types of factors.

Social Movements. Social movements have been active in the politics of abortion (Tatalovich & Daynes 1981). Social movement activity increased dramatically after the 1973 Supreme Court abortion

decision; the pro-choice movement claiming that all women should choose whether or not to obtain an abortion, and the pro-life movement stating that abortion is tantamount to murder. The political influence of these movements has ranged from supporting candidates with similar positions on abortion to initiating abortion related laws, such as public funding restrictions, informed consent laws, and licensing standards. To what extent have social movement activities had an impact on availability of abortion services? Social movement mobilization will be measured by a content analysis of newspaper articles reporting abortion movement activity.

Lifestyle Differences. Luker (1984) points out that the current debate over abortion involves differences of lifestyle. If abortion is seen as a symbolic issue manifesting a struggle of values and style of life, then it would be expected that 'moral climate' of a state would have a large impact on abortion services. Indicators of a cultural climate would include a measure of religious composition, and orientation toward the family.

Reproductive Rights: The Feminist Interpretation. Feminists suggest another interpretation of abortion. From their perspective abortion is a women's issue of reproductive rights (Gordon 1976; Petchesky 1980). If the current debate is seen as a continuation of women's struggle for reproductive freedom, then it would be expected that indicators of the status of women would affect availability of abortion services. A status of women index will be constructed to measure the position of women relative to men.

Abortion Restrictions. Since the 1973 Supreme Court decision,

states have pursued a variety of restrictions in attempts to deter abortion. Regulations have concentrated on raising the costs of having or providing abortion, through facility requirements, consultation by more than one doctor, residence requirements and limits on the use of public funds; and, by increasing the psychological costs of abortion, through spousal or parental consent and conscience clauses authorizing nonperformance of abortion (Johnson & Bond 1980). The economic aspect of abortion restrictions is highlighted by the Congressional passage of the Hyde Amendment (Jaffe, Lindheim & Lee 1981; Alan Guttmacher Institute 1980). In essence, the Hyde Amendment eliminated federal medicaid funds for abortions. States, however, could decide whether or not to continue to use state medicaid funds for abortion, and if so, how much and under what circumstances. It would be expected that restrictions of abortion would have a negative impact on availability of abortion services. A restrictiveness index based on the severity of state's laws will be used as an indicator of restrictions.

The Role of the Health Care System. In contrast to the various responses to the judicial ruling and explanations of the abortion debate, availability of services may be constrained by the characteristics of the health care system, and in direct response to demand for such services. If so, then state characteristics of the health care system, such as urbanism and physician availability; and populations with high demand for abortion care, such as race, education, marital status, and proportion of women of childbearing ages in the population, would explain state differences in

availability of abortion services.

Social policy does not just emerge. There is a process in which social policy responds to society and society responds to policy. Policies create various changes and these changes create new sets of social relations which may, in turn, affect the implementation of the policy itself. Building this model reflects the conceptualization of the various reactions and responses as foreseen and unforeseen consequences of the 1973 Supreme Court decision. The impact of these consequences for abortion availability is not clear cut. Testing this model will allow us to examine the consequences of abortion policy as potential social forces that may influence the availability of abortion services.

There is another, and somewhat implicit, objective of this research: to be useful. Social scientists are often concerned that their research is rarely used in the development of policy. Policy analysts, on the other hand, declare that the concerns of the discipline usually dictate the research questions investigated, rather than focusing on variables that can be manipulated (Scott and Shore 1979). In order to make an impact on policy, this research will focus on variables which can be policy relevant.

METHODOLOGY

The data for this research come from two principal sources. The data on availability and use of abortion services come from The Alan

Guttmacher Institute (AGI). Since 1974, the AGI has monitored "the availability of abortion services in all geographic areas in the country," and has collected information "about the abortion providers and the services they offer" (Henshaw 1983, p. i). Information regarding the social and political factors in each state comes from the State and Regional Indicators Archive at the University of New Hampshire. The Archive houses state level data from a variety of sources, with the primary source being the U. S. Census Bureau. The American states are the units of analysis (N=50).

The data analysis consists of three parts.

Trends in Abortion Services. Descriptive analyses of the changes in availability of abortion services over time will be described. State by state changes in availability from 1973 to 1982 will be examined. Henshaw et al. (1982), Frankel (1982), and Frankel and Ward (1984) have shown large state-to-state variation in abortion services. Looking at the changes in availability of abortion services over time will produce descriptive information about the pattern of variation on a state level.

Estimation of Abortion Services. Multiple regression will be used to test the influence of the five factors on the availability of abortion services. Social and political measures for 1976 and 1980 will be used to predict abortion availability for those same years. Since the analyses deal with two different time periods, it is necessary to place this study of abortion policy in a historical context and take into account the changes in the nature of the abortion debate. A pooled cross sectional and time series model will

be used to examine the effects of changes over time.

Types of Abortion Services. The third part in the data analysis is an exploratory investigation of the effects of social and political factors on the availability of specific types of abortion services as defined by The Alan Guttmacher Institute: hospitals, nonhospital facilities providing fewer than 400 abortions per year, and nonhospital facilities providing 400 or more abortions per year. The social and political variables used in the previous multiple regression analyses will be used in this portion of the data analysis. Research on abortion providers has generally focused on either one type of abortion provider (most likely the abortion clinic) or has looked at all providers together without taking into account their differences. If availability of abortion services is affected by various social and political structures and values, it seems reasonable to further inquire as to whether these factors similarly affect the different types of abortion services. If different factors affect different types of abortion services, then we need to ask what the implications are of these findings. Investigation of factors related to specific types of abortion providers will shed greater insight into the implementation process of the 1973 Supreme Court decision.

SIGNIFICANCE OF STUDY

For the most part, research focusing on abortion as policy in the

United States has concentrated on the relation among factors instrumental in creating legislation, i.e., the creation of policy. For example, Steinhoff and Diamond (1977) documented the experience of legislative reform in Hawaii prior to the 1973 decision, Mohr (1978) presented a detailed account of the evolution of abortion policy culminating in the Supreme Court decision, and Lader (1973) looked at the organizational impact of social movements leading to the 1973 Supreme Court decision. Two empirical studies (Smith 1975; Tatalovich & Daynes 1981) employed Lowi's categories of policy types in order to determine what role moral values played in the policy making process. However, the activities and events since the 1973 Supreme Court decision also provide an opportunity to study another dimension of policy - implementation. This study seeks a social interpretation of implementation by investigating the relations between groups, such as the organized abortion movements, and the conflict between differing lifestyles in American society in determining the implementation of abortion policy.

On a policy level, this research differs from the types of policy usually investigated. Traditionally, policy research has focused on "Congress' enactment of social-welfare or economic programs which allocate resources among population groups or sectors of the economy" (Tatalovich & Daynes 1984, p. 207). In contrast to these budgetary concerns, the issue of abortion has the ability to excite controversy, as witnessed by the history of cultural, religious and economic conflicts over abortion. Gusfield's study of the Temperance Movement was instrumental in emphasizing the social context of social

and political issues. His book Symbolic Crusade (1963) referred to certain political acts as symbolic for what they signify "about the style or culture which is being recognized or derogated" (p. 11). T. A. Smith (1975) extended this idea of symbolic action by referring to certain policies, including abortion, as "emotive symbolic" policies because they "generate support for deeply held values" (p. 90). Although there is increased recognition that policies have symbolic meanings, the empirical literature on such policies is a fragment of what is written and researched about policy. This study, then, will contribute to a growing body of research on symbolic policies.

This research also makes a contribution to our understanding of social policy and social movements by looking at the relation between social policy and social movements. The question of how social movements affect policy implementation is addressed in detail. Generally, these two areas are studied separately. Yet, very often it is some policy decision which gives rise to social movements or the activities of social movements which leads to a policy decision. At least some empirical answers may be suggestive of possible theoretical links between social movements and social policy.

On a practical level, this research is significant because it is a study of a policy that affects all women. As mentioned earlier, reproductive decisions shape all aspects of women's lives. Maternity may force upon a woman a distressful life and future; psychological harm associated with an unwanted child, as well as mental and physical wealth taxed by child care. Supposedly the Supreme Court decision

assured women access to safe, legal abortions. The continued lack of availability of abortion services to women in need of these services indicates that the opportunity to decide whether or not to obtain an abortion has not been equally available. The findings of this research may be useful for the purpose of better assessing problem areas and planning action in making abortion services available to all women who need them.

SUMMARY

The goal of this dissertation is to provide a sociological analysis of the implementation of abortion policy. In chapter two the policy implementation literature is discussed with a focus on the consequences of policy and the impact of these consequences on the implementation of the policy. It is argued that policies create both foreseen and unforeseen consequences which can be interpreted as affecting the implementation of a given policy. Using the concepts of foreseen and unforeseen consequences, a testable model of abortion services is constructed in chapter three. Implementation of abortion policy is reflected in the distribution of abortion services. Building this model involves conceptualizing the various social and political responses to the 1973 Supreme Court decision and explanations of the abortion debate, testing and interpreting their effects on the distribution and availability of abortion services. Chapters four and five present the design and results of the

statistical analyses used to test the model of implementation of abortion services. In chapter six the model is extended and tests the influence of these same social and political responses on the availability of different types of abortion services - hospitals, nonhospital facilities providing fewer than 400 abortions per year, and nonhospital facilities providing 400 or more abortions per year.

A model cannot be expected to explain every event. However, it is "a useful framework for categorizing events and discussing general tendencies" (Whitt 1982, p. 210). In the final chapter, the broader theoretical and practical implications of the findings of this study are discussed.

CHAPTER 2

POLICY IMPLEMENTATION: FORESEEN AND UNFORESEEN CONSEQUENCES

In this chapter a review of the major issues in the implementation field are highlighted. The implementation literature is fragmented. In part, this is due to the diverse disciplines represented by researchers studying implementation: economists, political scientists, organizational behaviorists, applied social scientists, and specialists, etc. What will become evident from this review is the neglect of a sociological perspective in the area of implementation. In terms of implementation, a sociological analysis would lead one to examine a particular set of policy consequences, such as those that involve changes or conflicts between groups. For example, what effects do social movements, or the struggle between groups based on different values, or the social conditions of gender relations have on implementation? The field of implementation is a relatively untapped area by sociologists. Blumer (1971) claimed that he knew of no other area of social problems less understood and less studied than implementation. After a review of the literature, the concepts of foreseen and unforeseen consequences are discussed. These concepts are then used to examine the various reactions and responses to the 1973 Supreme Court decision (Chapter 3). It is suggested that the concepts of foreseen and unforeseen consequences provide a useful framework for a sociological study of implementation.

IMPLEMENTATION AND CONSEQUENCES

Traditional Approaches to Implementation Analysis

The diverse backgrounds of the implementation analysts have led to many different conceptualizations of implementation. What varies among the definitions is how implementation is conceptualized (Alexander 1985). At the one end of the continuum, the focus is on the organization or organizations directly involved in implementing the policy decision. Generally, researchers at this end of the continuum view implementation as a stage of the policy making process, and emphasize the various aspects of those organizations responsible for the implementation of a policy decision. At the other end of the continuum, analysts attempt to account for the policy context in which implementation occurs. Here, implementation is viewed as a process, and the researcher attempts to "capture the dynamic nature of implementation" by focusing on the often complex interrelationships within the political system (Sabatier & Mazmanian 1980; Jenkins 1978). In between these ends, analysts vary in their attention to the organizational context and the political context of the policy making process.

Researchers emphasizing aspects of the organizations have a narrow definition of implementation. Their analyses are limited to the underlying administrating organizations associated with implementation in order to better understand the translation of policies (Berman 1978). Attention may be placed on the many interactions within the

implementating organizations (Jenkins 1978), or on the patterns of cooperation among organizations when the combined efforts of two or more agencies are responsible for implementation (O'Toole & Montjoy 1984). Other research may highlight the organizational context of the agency by emphasizing such aspects as the type of organization (federal, state, local, etc.) or the resources available in order to document the difficulties in executing policies. Berman (1978) asserted that the characteristics of the institutional setting shape implementation. He concluded that since the outcome of policy depends on its passage through organizations, implementation analysts need to study how changes occur within organizations.

Whether emphasizing characteristics within or between organizations, the organizational perspective of implementation is constraining. Using the organizational approach, implementation analysis of abortion policy would focus on the medical establishment and its role in implementing the Supreme Court decision. Such an investigation may look at a range of issues, such as who within the medical setting determines abortion procedures, organizational norms, influence and authority differentials, or resource deficiencies. The advantage of having a limited domain of analyses is that it enables "clear specification of a few salient variables" (Alexander 1985, p. 410). However, such an approach runs the risk of asking the wrong questions and neglecting important factors. Criticisms tend to fault the organizational approach for creating a static picture of implementation based on simple assumptions of causation. Implementation is seen as a stage of policy making separated from

other aspects of the policy environment. According to the critics, conceptualizing implementation as a stage is inadequate because it ignores "important forces" which may have a bearing upon "both political arrangements and public policy" (Munns 1975, p. 651).

In contrast, other researchers tend to conceptualize implementation as a process. This approach emphasizes the context of the policy environment in which implementation occurs by focusing on the interrelationship between the political system and the administrating organizations. What differentiates this research is the varying importance researchers attribute to the organization versus the characteristics of the political system. For many researchers, the implementing agency remains central to the implementation process, however, now the organization is viewed within a context that includes characteristics of the political system. Jenkins (1978) argued that a focus on how organizations outside and inside the political system conduct their affairs and interact with one another is central to understanding the implementation process. Van Meter and Van Horn (1975) and Sabatier and Mazmanian (1980) constructed elaborate models of implementation. The purpose of model-building was to systematically identify those organizational factors as well as specific policy context factors which affected the achievement of policy objectives.

The research of Jenkins (1978), Van Meter and Van Horn (1975), and Sabatier and Mazmanian (1980) is representative of the implementation literature that identifies specific aspects of organizations in conjunction with the characteristics of the political system. These

characteristics may include such factors as the availability of resources (human and economic), properties of the policy, or motivation of actors to comply with policy decisions. Still, other researchers attend more to the policy environment than specific characteristics of the implementing organization(s). Emphasis is on implementation within the structure of the political system. According to Pressman and Wildavsky (1979), implementation is not dependent on characteristics intrinsic to the organization, but is attributable to the ambiguity among policy makers concerning how a decision should be implemented. What finally emerges as implementation is the result of the combined effects of organizations left to their own devices to try and implement a decision successfully, and the various political constraints associated with a policy decision. Difficulties, therefore, arise because implementation is divorced from policy (Pressman & Wildavsky 1979). In terms of abortion policy, the 1973 Supreme Court ruling did not solve the dilemma of abortion. In fact, legislative actions and reactions attempted to constrain the judicial rulings.

In their article, "Implementation as Evolution," Majone and Wildavsky (1978) argued that when policy is enacted new circumstances are created which allows for the actualization of "different potentials in whatever policy ideas we are implementating" (p. 114). According to these researchers, the task of implementation analysis is to discover the "constraints under which policies may be expected to operate" (p. 113). Implementation analysis also involves the evaluation of policy ideas, and as with scientific theories, ideas are

never proven right but only "gain increasing acceptance" (p. 116).

Common to these studies that emphasize the process of implementation is the focus on the context in which implementation occurs. However, these studies have also shown the differences among researchers in understanding and analyzing the policy context. The empirical models attempt to subsume everything under 'implementation' and often create an unmanageable system for analysis. According to Alexander (1985) the analyst "risks information loss by failing to distinguish between the different stages of the process that in fact transforms policy into action" (p. 410). For Pressman and Wildavsky (1979) and Majone and Wildavsky (1978) implementation involves not isolating policy from implementation, or separating the idea from action. The purpose of analysis, therefore, is to bring policy and implementation into closer correspondence (Pressman & Wildavsky 1978).

Unforeseen Consequences

In general these studies reveal a somewhat limited view of implementation, whether conceptualized as a stage or process, or approached from a political or organizational perspective. The research on implementation is limited to identifying those factors related to organizations or political structures that are directly associated with a given policy. As shown in the studies above, these factors often include various forms and interactions of the implementing agencies, the values and views of the policy makers, or the political methods for processing demands (Munns 1975). However, policies affect more than just those institutions directly associated

with a policy. Policies generate change beyond the boundaries which are encompassed by the organization(s), political system and programmatic direction, and these changes create a feedback loop to the implementation of the policy itself. A few researchers have recognized the importance of these 'other' consequences or effects associated with a policy decision. Blumer (1971) noted that as a plan is put into practice it "is modified, twisted and reshaped, and this takes on unforeseen accretions" (p. 304). These unintended transformations or unforeseen consequences restructure "the area of a social problem that arises from the implementation of an official plan..." (Blumer 1971, p. 305). Whitt (1982) claimed that through social policy actions are undertaken which produce unsought consequences and constrain future social action. The resulting social strain and conflict undermine "effective action and institutional functioning" (p. 30). Often another policy is then created to control the unintended consequences.

The concept of unanticipated or unforeseen consequences is similar to Merton's (1968) concept of latent functioning of social action. Accordingly, latent functions refer to consequences of action which produce results neither intended nor recognized by participants in a given system. The heuristic value of the concept of unforeseen consequences is that the researcher's attention is extended beyond whether or not the policy attained its avowed purpose. Merton (1968) suggested that the distinctive "contributions of the sociologist are found primarily in the study of unintended consequences of social practices, as well as the study of anticipated consequences" (p. 120).

A few empirical studies have attempted to examine the influence of 'outside' influences on policy implementation. Alexander (1985) and Sabatier and Mazmanian (1980) attempted to incorporate these outside influences into a model of implementation. Alexander (1985) proposed a contingency model of implementation that included both external environmental factors, as well as institutional factors affecting implementation. His "external environment", was defined as "either the analysts' 'objective' environment" or the environment as perceived by those participants actually implementing the policy (p. 417). It certainly is not clear what Alexander meant by this "external environment", nor how one would measure it. Sabatier and Mazmanian (1980) identified the following non-statutory variables as affecting implementation: variation in social, economic and technological conditions over time and among settings, media support, public support, constituency support and resources, and 'sovereigns' support. They suggested that in the long run non-statutory variables were more important to the implementation process than the statutory variables. This conclusion, however, was based on various scenarios rather than any empirical analyses. In contrast to Alexander's ambiguous external environment, the factors identified by Sabatier and Mazmanian provide a more substantial base with which to begin investigating these external factors. Whether these consequences are called unintended (Whitt 1982), or non-statutory variables (Sabatier & Mazmanian 1980), they all refer to the effects of policies beyond programmatic goals and the boundaries of the associated organizations. This implies that there is a larger context in which policies have consequences. The

effects of policies need to be examined in terms of consequences in a wide variety of areas. However, there is little agreement about what these effects are and, to date, there has been no systematic investigation of these unforeseen consequences. It is suggested that a sociological analysis of implementation would facilitate examining the foreseen and unforeseen consequences of policies. In the next section the concepts of foreseen and unforeseen consequences in terms of policy analysis are developed.

FORESEEN AND UNFORESEEN CONSEQUENCES

A criticism of the current implementation literature is that it neglects the social context in which policy occurs, and it minimizes attention to consequences of policies beyond the impact of programmatic goals. Attention is often restricted to those organizations or political systems directly involved in the implementation of the policy. It seems that a task of implementation analysis is to discover the constraints under which policies may be expected to operate. This task would include investigation of programmatic goals, as well as the effects found in the events of every day social life. One contribution of a sociological analysis of implementation, therefore, would focus on the social conditions under which policies are implemented and the impact of these conditions on the implementation. Terms such as 'social context' and 'social conditions' are abstract concepts that need to be explained. For

purposes of this research, the context of implementation refers to the interrelationship between foreseen and unforeseen consequences of policies. The theoretical works of Joseph Gusfield provide a useful framework for understanding the foreseen and unforeseen consequences of policy. In the paper, "Social Movements and Social Change: Perspectives of Linearity and Fluidity" (1981), Gusfield distinguished between a linear and a fluid conception of social movements. His linear and fluid images of social movements parallel the concepts of foreseen and unforeseen consequences, respectively. Although Gusfield specifically addressed social movements, it is thought that these concepts can be generalized to other social phenomena, such as social policy. In fact, the concepts of fluidity and linearity seem particularly relevant to social policy since policies, as well as social movements, involve actions concerned with social change.

According to Gusfield, a linear perspective of social movements emphasizes the "deliberate pursuit of change by an association of partisans" (p. 322). Attention is focused on an "association of people whose activity is perceived as using means to gain an end" (p. 319). Characteristics of the linear perspective that are applicable to the concept of foreseen consequences include, 1) the focus on specific organizations and associations of social movements (social policy), and 2) the "concern for change as success or failure of movements (policy) seen in their own terms" (p. 320). These characteristics of the linear perspective resemble those elements common in the current implementation literature, namely its limited focus on the intended purpose of the stated policy in relation to the

associated organization(s) and political environment. Using the linear framework, implementation would be evaluated in terms of whether or not a policy met its programmatic goals - its foreseen consequences. In terms of abortion policy and this research, foreseen consequences refer to responses by groups or institutions directly involved with implementing the Supreme Court decision, and whose actions have a direct effect on the availability of abortion services.

In contrast, a fluid perspective emphasizes the cultural side of social movements (Gusfield 1981). Offered as another approach to the study of social movements, the fluid perspective:

> ... is less confined to the boundaries of organizations and more alive to the larger context of change at the same time as it is open to awareness of how the movement has consequences and impacts among non-partisans and nonmembers as well as participants and devotees... it is more likely to lead to questions about consequences: what happened? (p. 323).

For example, the Civil Rights Movement meant more than just the passing of various legislation, it contributed to changes in black-white relations; the Prohibition Movement's attainment of the 18th amendment symbolized the struggle of two divergent lifestyles; and the Women's Movement and the Gay Rights Movement have been significant in the ways "in which sexual and gender relationships are constructed and evaluated" (Gusfield 1981, p. 321). In essence, the focus is shifted "away from the short run search for goals and goal realization and toward the less political parts of human life in long-run perspective (Gusfield 1981, p. 323). Furthermore, what makes these unforeseen consequences sociological is the focus on changes in the structured patterns between groups.

The implications of this perspective is the recognition that

change associated with social policy occurs on several levels, not just the political and organizational levels. The administrating organizations and the political structure may affect policy implementation, but they are not the only factors which have an impact. For example, Gusfield (1981) has emphasized that social movements are associated with change in a wide variety of areas. Social movements have been credited with achieving changes in policies; and, alternatively, it has been suggested that social movement activity may be initiated by policies. In relation to social policy, it seems likely that the activity of social movements can create conflict and eventually "undermine effective action and institutional functioning" (Whitt 1982, p. 30).

The concepts of foreseen and unforeseen consequences facilitate examination of the various responses to the Supreme Court decision by different social groups, such as the activities of the abortion movements. It is further suggested that these consequences influence the implementation of abortion policy, that is the availability of abortion services. The task of this research is to discover the foreseen and unforeseen consequences of abortion policy. Further, I will investigate the effects of these consequences for the availability of abortion services. It was stated earlier that a sociological analysis of abortion would focus on the social conditions under which policies are implemented. Besides social movement activity, other social conditions that may affect abortion policy implementation could include the prevailing ideology or the cultural climate, that is the various attitudes, values or beliefs associated

or symbolized by abortion and abortion policy, or the economic divisions in society. Attention to the effects of the organizational and political levels is not to be ignored. Rather, the study of unforeseen consequences, as well as the foreseen consequences are to be included in a sociological analysis of implementation. The role of the sociologist in the study of policy implementation is to observe and tell "what is happening from as wide a perspective as he or she, the observer, concludes is relevant" (Gusfield 1981, p. 336).

SUMMARY

The current implementation literature ignores the social context in which implementation occurs. Traditional analyses are limiting in their focus on the organizations and political systems directly associated with a given policy - the foreseen consequences. However, policies often have unforeseen long range consequences that may restructure the official policy and affect its implementation (Blumer 1971). Gusfield's (1981) perspective of linearity and fluidity in the study of social movements was used to develop the concepts of foreseen and unforeseen consequences of social policy. It has been suggested that a sociological analysis of implementation is enhanced by investigating the foreseen and unforeseen consequences of policies. In the next chapter the various consequences of abortion policy are examined as factors that may influence the implementation of the Supreme Court decision.

Chapter 3

A SOCIOLOGICAL APPROACH TO ABORTION POLICY IN THE UNITED STATES

The 1973 Supreme Court decision "established a national policy recognizing the right of a woman to terminate an unwanted pregnancy" (Bond & Johnson 1982, p. 1). This policy emerged in a context of dramatic changes in public consciousness and attitudes regarding abortion. According to Palley (1979) the court ruling "was rendered in an atmosphere of considerable political cleavage based on disagreement regarding basic social and human values" (p. 131).

The judicial decision opened up a foray of action and reaction from several sectors of society, including women, doctors, health institutions, legislatures and courts, and a variety of government institutions (Jaffe, Lindheim & Lee 1981). On a moral level, the judicial ruling stated that the decision about whether or not to terminate a pregnancy was a matter of privacy between a woman and her physician. In response, social movements emerged claiming that abortion was not a matter of private decision-making but rather an issue concerning the taking of a life. On an organizational level, the legalization of abortion created a demand for health services through which abortion could be obtained. The health care system responded by attaching an amendment to the Health Services Act which exempted health care facilities from "being 'forced' to provide or perform abortions which were against their moral or religious views"

(Palley 1979, p. 139). And finally, on a state level, the Supreme Court decision took power to regulate abortion away from the state. States, in turn, responded to this loss of their rights by passing legislation concerning their proportion of the payment of abortions through Medicaid.

Today, over 10 years after the Supreme Court decision, deliberations continue "over the implications of abortion for welfare policy, civil liberties, race relations, religion, and women's rights" (Hansen 1980, p. 372). At the same time, abortion services remain unequally available to women in need of them. The Supreme Court decision guaranteed women the right to choose whether or not to obtain an abortion. In response to the Supreme Court ruling "services would be needed to meet the new medical and social situations created by the availability of abortion" (Steinhoff & Diamond 1977, p. 76). However, the ruling required "neither the states nor the medical community to provide those services" (Bond & Johnson 1982, p. 2). Thus, the provision of services has not been monitored or consistent across the country. Consequently, the opportunity to act on the decision whether or not to obtain an abortion has not been equally available. Since 1973 the Alan Guttmacher Institute has observed the changes in the abortion rate and has estimated the number of women unable to obtain abortions. Repeatedly, researchers associated with the Institute have pointed out the uneven distribution of abortion services across regions, among states, and between rural and non-rural areas of the country. Relatively neglected in the research literature on abortion is the question of those factors that account for the uneven

distribution of abortion services.

In chapter one it was stated that investigation of the factors that influence the availability of abortion services is a study of policy implementation. In general, traditional implementation analyses tend to examine a narrow range of consequences of a given policy. Based on this conventional approach, an analysis of abortion services would focus on the organizations or political systems directly associated with abortion policy; that is, the response of the medical community after the 1973 Supreme Court decision. This type of investigation would tend to view the availability of services as a direct response to the demand for such services, or focus "on organizational variables as the major determinants of actions to implement" policy (Bond & Johnson 1982, p. 20). For example, Legge (1985) and Hansen (1980) investigated the implementation of abortion policy by looking at the impact legal abortion had on several health indicators, such as birth rates, abortion related maternal deaths, and infant, neonatal and fetal mortality rates. Hansen (1980) found no major declines in birth rates since the Supreme Court decision. Legge (1985) found that several maternal indicators had shown improvement which he attributed to changes in abortion policy as well as expansion of the health care industry. But abortion policy has a history and a context. As mentioned above, the Supreme Court decision elicited a variety of responses, and unanticipated consequences. The continual challenges to the Supreme Court decision aimed at limiting abortion, and the rapid moblilization of anti-abortion movements illustrate some of the unintended responses to the Supreme Court decision. These responses

do not promote a social climate which assures availability of abortion services. Yet, challenges to the court decision and social movement activity have been vital components of the abortion debate since 1973. What effect these various unforseen consequences have on the availability of abortion services is an empirical question. Certainly the demand for abortion services is a determinant of the availability of abortion services. However, to investigate the availability of abortion services without considering these unanticipated activities and other social changes that occur as a result of the policy is limiting. An approach is needed which sees the demand for services as a determinant and not the determinant of availability of abortion services. In chapter two it was suggested that a sociological analysis of implementation would be enhanced by investigating foreseen and unforseen consequences of a policy and their effects on implementation. This framework is used to investigate factors that may influence the availability of abortion services.

This chapter contains three parts. In the first part a history of abortion policy is presented. Included within this section is the background of the legalization of abortion prior to the 1973 Supreme Court decision, and the legal cases on which the Supreme Court decisions were based. Following this chronology, the literature on abortion services and other fertility-related services is reviewed. In the final part of this chapter, the various social and political responses since the Supreme Court decision are discussed in the context of their implications for the availability of abortion services. In Chapter 4, these factors are operationalized for

inclusion in the model. This model, based on the ideas of foreseen and unforseen reactions to abortion and its legal status, will test the influence that these responses have on the availability of abortion services.

ABORTION POLICY IN THE UNITED STATES

Since the nineteenth century abortion has been a social policy issue. In the early 1800's the American legal status of the practice of abortion was based upon the traditional British common law "which held that abortion was not a crime prior to 'quickening', the period of time when movement of the fetus is felt" (Legge 1985, p. 20). Between 1821 and 1840, 10 states passed anti-abortion laws which were inserted into each state's criminal codebook. These early abortion laws were "aimed at regulating the activities of apothecaries and physicians" for the reasons of public safety (Mohr 1978, p. 43). Thus, the "person who administered the abortifacient or performed the operation was punished" (Mohr 1978, p. 43).

During the 1840's significant changes occurred in the pattern of abortion, such as increased visibility of "the fact that Americans practiced abortion," a sharp rise in the overall incidence of abortion, and the increased "use of abortion by white, married, Protestant, native-born women of the middle and upper classes" (Mohr 1978, p. 46). One response to these changes was the introduction and enactment of abortion related legislation. Physicians, especially,

were a significant force in initiating anti-abortion legislation. The involvement of physicians was due in part to competition from non-medical licensed abortionists, as well as an effort to improve and professionalize the practice of medicine. During this time it was discovered that many practitioners did more than just provide abortion services, "but that some practitioners had made the abortion business their chief livlihood" (Mohr 1978, p. 47). At first, major revisions in the criminal codes were enacted, with the major focus on eliminating commercial abortionists. However, as the crusade continued, state laws were created shifting the blame to women seeking abortions as well as the abortionists. The effort to secure "increased credibility of physicians as professionals on health related issues" was one of the factors which led to labeling abortion as murder and the concern for the safety of women obtained abortions (Mohr 1978, p. 203).

Between 1860 and 1880 anti-abortion laws were gradually introduced into state legislatures and ratified. By 1880 a great majority of the states had adopted some kind of anti-abortion legislation. For the following eighty years, these laws were either maintained, or some minor refinements, adjustments or restatements were added to the anti-abortion laws.

The movement for change from these restrictive laws began in the late 1960's. Several states proposed changes to their anti-abortion laws in the direction of increased flexibility and tolerance. The interest in abortion at this time centered on health issues, and coincided with an overall public concern about the ecological and

social problems of pollution and population (Steinhoff & Diamond 1977). On January 22, 1973, the Supreme Court passed judgment on two abortion cases which had a profound impact on policy concerning abortion. In the case of ROE v. WADE, the Supreme Court debated whether the 1857 Texas anti-abortion statute which prohibited abortion except "for the purpose of saving the life of the mother" violated the United States constitution. The Court based its decision on the Fourteenth Amendment right to privacy, arguing that this right to privacy encompassed a woman's decision whether or not to terminate her pregnancy. During the first trimester, the decision was left to the woman and her physician. However, during the second and third trimesters, the laws of the state could intervene to restrict availability of abortion in such cases where preservation of the mother's life was involved (Palley 1979).

In the Georgia decision, DOE v BOLTON, the Supreme Court dealt with four issues of state abortion requirements: residence requirements, accreditation of hospitals where abortion services were to be performed, abortion committee requirements, and the need for concurrence of two doctors, other than the attending physician, in abortion decisions. In essence, the Supreme Court held unconstitutional those requirements which placed special barriers on hospitals and health care facilities in the area of abortion services which did not apply in other areas of health services (Palley 1979).

Soon after the 1973 Supreme Court decision, Congress and state legislatures made numerous attempts to limit abortions. With two exceptions, the "courts have struck down virtually all of these

limitations" (Bond & Johnson 1982, p. 2). One initial challenge to the Supreme Court decision occurred in 1973. Senator Frank Church (D-Idaho) introduced an amendment to the Public Health Services Act which "exempted institutions as well as individuals from being 'forced' to provide or perform abortions which were against their moral or religious views (Palley 1979, p. 139). The implication of this amendment was that tax-supported hospitals were not required to assume responsibility for the provision of abortion services. The second successful challenge to the Supreme Court decision was the 1977 Congressional restriction on the use of public funds for abortion. The restriction means that Medicaid payments for abortion are unavailable to low-income women. Thus, the Supreme Court assured women the right to obtain an abortion and prohibited states "from limiting the provision of abortion services, clinics and hospitals," but the Court did not require states "nor the medical community" to provide such services (Bond & Johnson 1982, p. 2). The lesson soon learned was "that abstract legal guarantees of 'a woman's right to choose' are not equivalent to the actual delivery of adequate abortion services to all women who need and want them" (Petchesky 1984, p. 157).

This account of abortion policy over time has been included in this chapter in order to provide a background for understanding and examining the current abortion debate. Furthermore, this section provides a historical perspective with which to approach the sociological conceptualization of factors that may affect availability of services. In the next section, the empirical literature examining

the determinants of abortion services and other fertility related services is reviewed. Fertility related services refers to services offering methods to regulate the timing or control of births. Since abortion is used as a method of regulating births, the link with other fertility related services is pertinent. Research findings about factors associated with fertility control may be useful in gaining a broader background and understanding of the distribution of abortion services.

ABORTION AND FERTILITY-RELATED SERVICES

Abortion Services

A direct result of the 1973 Supreme Court decision has been the increase in the number of abortion services. However, the increase in availability of services has proceeded slowly and unevenly. According to the Alan Guttmacher Institute (Henshaw, Forrest, Sullivan & Tietze 1983), "since 1976 the extension of abortion services to previously unserved areas has proceeded at a slow pace, after the substantial gains that were registered between 1973 an 1976" (p. 3). In attempting to account for the unequal dispersion of abortion services, several investigators have cited the importance of a combination of political constraints and restrictive medical policies (Jaffe et al. 1981; Palley 1979; Bond & Johnson 1982; Legge 1985).

In several empirical studies the determinants of abortion services have been examined in conjunction with the estimation of the overall

effects of various social, political, and environmental variables on abortion rates. Common to these studies was the finding that the number of abortion services was the single most important predictor of the abortion rate, and that abortion services mediated most of the effects of the various social, political and demographic variables on the abortion rate. However, there was little consistency among these studies in determining what factors influenced the availability of abortion services.

Borders and Cutright (1979) found several environmental variables to be significant predictors of community abortion services in the years 1973 and 1975: physician density, public assistance, and marital status in a positive direction, and low education in a negative direction. In addition, low income and women's labor force participation were significant determinants of the 1975 provider rates.

Hansen (1980) constructed a causal model in which she identified the direct and indirect effects of population characteristics and political constraints on availability of abortion services and state abortion rates in 1976. Her results showed that the provision of abortion services depended on medicaid funding for family planning, legislative support for abortion funding, passage of liberal abortion policies prior to 1973, unwanted fertility rates, and population size.

Using 1976 data, Frankel (1982) found that the overall status of women, state expenditures, and the absence of state restrictions to be significant determinants of the availability of abortion services. Both Hansen (1980) and Frankel (1982) found political support to be

associated with greater availability of abortion services in the 50 states. Hansen (1980) used votes in support of abortion by each state's congressional delegation as an indicator of political support; whereas, Frankel (1982) used a measure based on the number of restrictive abortion policies in each state.

Frankel and Ward (1984) examined the effect of several social and political variables on the availability of abortion services in 1980. Their research showed the status of women as measured by income, low population density, and region to be important determinants of the provider rate. The puzzling finding from this study was the negative effect of population size. Frankel and Ward (1984) concluded that, "the negative effect can be interpreted in terms of efficiency of service delivery; in urban states, populations are more concentrated and can be served by a smaller number of providers, relative to population size, than in a more rural state where more providers are needed to service a more dispersed population" (p. 9).

Henry (1978) explored "the spatial bias of abortion facility location" by attempting to identify factors that explained the diffusion pattern of services in the Northeastern United States (p. 7). According to Henry (1978) abortion service location has followed a pattern of urban hierarchy; that is, initially services were established in larger urban areas shortly after abortion was legalized, followed by an increase in the number of facilities in these initial areas, and then the location of new facilities in smaller urban areas. However, given this descriptive pattern of diffusion, "abortion services are not uniformly available in urban

areas" (Henry & Harvey 1982, p. 987). Henry (1978) found two other factors, in conjunction with large populations, which influenced abortion service location: geographical areas with a large number of females, and the passage of enabling legislation. Similar to the state level analyses of Hansen (1980) and Frankel (1982), Henry (1978) found population size and enabling legislation to be important determinants of abortion facility location.

A criticism of these studies briefly reviewed above is that they neglected to provide a framework for understanding the connections of relationships among those factors found to be relevant. Each study, in its own right, identified important determinants which showed statistically significant relationships with abortion services. Population factors reflect differing needs or demands for abortion services. In this context then, the distribution of abortion services is similar to any other health care service. It is interesting to note that whatever indicator was used as a measure of political support - abortion votes by state's congressional delegation, state restrictions, or enabling legislation - the results all showed it to be a significantly related to abortion services. This finding was consistent for the different years in which availability of services was estimated. Together, these articles imply that the political and demographic environment might influence the availability of abortion services. These studies seem limited in light of the complexity and controversial nature of the abortion issue. The research reviewed in this section sought explanation, and provided no suggestions about how services could become available to all women in need of such services.

Perhaps, looking at the social conditions that influence the availability of family planning services will be useful in conceptualizing factors that relate to the availability of abortion services.

Fertility-Related Services

Brown and Philliber (1977) examined the growth patterns of planned parenthood affiliates. Similar to Henry (1978), they found that diffusion began in largest cities and eventually moved toward surrounding communities of smaller size. Larger cities contained both a particular population with a need for services and the increased likelihood of organizational capacity. Another finding was a distinct growth pattern over time of planned parenthood affiliates; an increase in growth in the number of services between 1916 and 1940, a slow growth period from 1940 to 1960, and another spurt of high growth from 1961 to 1973. In trying to explain this pattern, Brown and Philliber (1977) suggested that 'related social events' may have been an impetus for the sudden increase in the number of planned parenthood affiliates. Although the authors did not discuss the influence of these 'social events' on the growth pattern of planned parenthood affiliates, it is significant that the authors suggested that a given social climate could affect the distribution of abortion services.

Hout (1977) studied the effects of demographic conditions, socioeconomic factors, health care and family planning program activities on patient enrollment rates in 1969 and 1971. In trying to explain the change in enrollment rates between the two years, Hout (1977) found that family planning program activities had significant

positive effects on enrollment rates. The direct effects of the environmental factors were not large. Hout (1977) concluded that both the program activity variables and health care indicators mediated most of the demographic and socioeconomic effects. Hout's work highlights the importance of examining the socioeconomic environment in attempts to estimate the impact of a policy instrument, such as family planning clinic types and location, on a policy outcome, such as patient enrollment rate in family planning services.

Kammeyer, Yetman and McClendon (1974) examined whether the availability of county family planning services was a response to poverty and high fertility or to a large black population. Their research indicated that family planning services were more likely to be available in counties with large black populations. This finding remained significant when poverty status, urbanization, and fertility rate were controlled. The authors concluded that the racial composition of local populations was influential in determining the availability of family planning services. Furthermore, their study indicated "that race may be a crucial latent determinant of policies and programs in which it is generally assumed that such considerations are absent" (p. 689). Wright (1978), however, claimed that another interpretation of that data was plausible: "that greater family planning services to blacks are a reflection of policy makers' desires to help a largely disadvantaged minority" (p. 1088). Wright (1978) tested these two explanations by investigating several factors in relation to the availability of different types of family planning services, such as services offered through the county versus through

Planned Parenthood and the Office of Economic Opportunity. The results indicated that the level of urbanization accounted for the distribution of non-local family planning organizations - Planned Parenthood and the Office of Economic Opportunity. However, the findings also showed a strong relationship between black concentration and the availability of county family planning services. Wright (1978) concluded that indeed race seemed to be an important determinant of the availability of locally sponsored family planning services.

Summary

In summary, previous research yields a mixed picture on the availability of fertility related service, including abortion, on a state level. Several investigators found that various demographic and socioeconomic variables were important factors influencing availability of services, while other researchers found specific factors, such as enabling legislation or program activity to be related to availability and location of services. Urbanization and percent black consistently appeared as important variables associated with the location and availability of abortion and other fertility related services.

While these studies are somewhat helpful in gaining a better perspective about fertility services, they are atheoretical. In contrast this study attempts to develop a more theoretically grounded model of the determinants of the distribution of abortion services.

A policy framework is used to explore and analyze what factors have an effect on abortion services. Availability of abortion services is

viewed as a measure of the implementation of the 1973 Supreme Court decision. In conceptualizing which factors may be related to abortion services, I looked at the various reactions to legalized abortion since the Supreme Court decision -- the various outcries in support and against the policy, the efforts to overturn the rulings, and the lack of attention by the health care community. These responses, in turn, will be interpreted as consequences of the policy, and as potential factors that may influence the availability of abortion services.

In the following section, the different responses to the judicial rulings and explanations of the abortion debate are presented. The various responses and explanations are conceptualized in terms of five factors: the role of pro- and anti-abortion social movements in the political conflict over abortion; lifestyle differences between abortion advocates and opponents; the larger feminist struggle for reproductive rights for women; the attempts to control abortion through restrictions; and the role of the health care system, in terms of the characteristics associated with adequate provision of health care services and the characteristics of demand populations for abortion care. Each factor implies a different set of components which is important for understanding variations in abortion services across states.

FIVE DIMENSIONS OF THE CURRENT ABORTION ISSUE

Social Movements

The first factor refers to the role of social movement activity in the abortion debate, and the influence of the abortion movements on the implementation of the Supreme Court decision. It is suggested that the strength of social movement activity effects availability of abortion services; that is, pro-abortion movement activity tends to be linked with increased availability of services, whereas anti-abortion movement tactics discourage availability of services. Activist social groups have played an important role in the history of abortion. Social movement activity has been important to both sides of the current abortion dispute. During the 1960's, advocates for abortion reform included health care professionals and "a cadre of activists belonging to ad hoc groups" (Tatalovich & Daynes 1984, p. 213). Eventually, the advocates organized the National Association for Humane Abortion organized in 1965 and established the National Association for Repeal of Abortion Laws in 1969 (Tatalovich & Daynes 1984). The activities of this group, along with other organizations, were crucial to the momentum leading to the 1973 Supreme Court rulings. However, once the Supreme Court decision was announced, many abortion advocates believed that the battle was won and that the changes sought had been realized; abortion was safe and legal.

Soon after the 1973 decision, social movements opposed to the judicial rulings rapidly organized and emerged as a contentious and

dynamic force in the modern abortion dispute. In essence, their goal has been the restriction and elimination of legal abortion (Conover & Gray 1983). An initial success by abortion opponents occurred in 1973. Senator Frank Church (D-Idaho) successfully introduced an amendment to the Public Health Services Act which "exempted institutions as well as individuals from being 'forced' to provide or perform abortions which were against their moral or religious views" (Palley 1979, p. 139). The anti-abortion movement continued to gain momentum when Congress, in September 1976, "passed a law which banned the use of federal funds to perform abortions for the poor unless the mother's life was endangered by pregnancy" (Palley 1979, p. 139). In the wake of the political defeats of advocates of abortion rights, the pro-abortion movement became more intensely active. Jaffe, Lindheim and Lee (1981) noted that the pro-abortion movement "began to speak up again only after abortion rights had begun to be eroded by restrictions on public funding and anti-abortion efforts to block the availability of abortion for all women" (p. 117).

Neil Smelser (1962) observed that one condition which facilitates mobilization of social movements is social changes which threaten or challenge traditional norms. Smelser's observation helps to understand and to explain the visibility of counter-organizations in response to the Supreme Court decision, and the reemergence of the pro-abortion movement. Each movement responded to actual and/or threatened changes; the rise of the anti-abortion movement was in response to the 1973 repeal of restrictive abortion laws, and the pro-abortion movement mobilized when challenges to the legal right were

perceived as serious.

The influence of social movement activity on policy implementation is important for this research. The following section addresses three issues: first, the theories of social movements in terms of current abortion movements; second, a description of the growth and activities of these movements; and third, the implications of abortion movement activities for the availability of abortion services.

Social Movement Theories. Theories of social movements account for a wide range of movement phenomena. Social psychological, or micro level, theories tend to place emphasis on the structure of the social movements themselves, such as why they arise and who participates. Traditionally referred to as the collective behavior approach, social movements within this framework are seen as responses to structural strains "which disturbs the equilibrium of the social system" (Melucci 1980, p.200). Two theoretical variations which attempt to explain why people participate in social movements are the theories of mass society and relative deprivation. Both point to a breakdown or "dissolution of traditional functions and communal solidarities" (Oberschall 1978, p. 297-298). Social movements are seen as a type of deviant behavior symptomatic of a society in serious trouble (Conover & Gray 1983).

In recent years there has been a shift in theoretical emphasis and away from collective behavior analysis (Zald 1980). Current theories argue that social movements are not irrational activities, and instead focus on the structural features that produce protest activities, as well as the consequences of social movements and conflict. The

resource mobilization perspective, in its various forms, is representative of this recent theoretical shift. For instance, the economic slant emphasizes "the infrastructure of societal support, industry competition, cost benefit modes of mobilization, and the like" (Zald 1980, p. 61). In its political form, based on the work of Charles Tilly (1978), social movement activity is "affected by the political structures and processes of the larger society" (Zald 1980, p. 62). Whatever its form, resource mobilization approaches portray the activities of social movements as rational and goal directed, and attend to the importance of social movements within larger societal processes and institutional structures.

A modified version of the resource mobilization perspective is used in this research as a framework to examine the abortion movements and their consequences for policy implementation. Specifically, social movements are viewed as "collective behaviors . . . oriented toward achieving specific goals, particularly the goal of exacting or resisting social change" (Langton 1987, p. 51). Social movement activity is portrayed as the mobilization and allocation of resources in order to best achieve those goals (Gamson 1975).

There are two features of the resource mobilization perspective of social movements which are not included in this research. One is the consideration of the structure of a social movement in relation to its counter-movement. Zald (1980) pointed out that "[M]uch of the mobilization potential, its tactics, and its ultimate fate stem from its battles with a counter-movement" (p. 62). Although the interaction between the pro- and anti- abortion movements may be

theoretically fascinating, it is not within the scope of this research. Rather, I am interested in the activities and tactics used by these social movements to inspire the changes desired. Another feature of resource mobilization theory is its conceptualization of the structure of social movements. In developing their perspective, McCarthy and Zald (1977) used terms such as 'resource mobilization industry' (RMI) and 'social movements organization' (SMO) to define social movements as "an industry" with smaller organizations "striving for a similar change of goals in a society" (Zald 1980, p. 62). Admittedly, the anti- and pro- abortion movements are comprised of several organized groups. However, since the National Abortion Rights Action League (NARAL) and The National Right to Life Committee (NRLC) represent the umbrella organizations under which other groups are affiliated, this research will focus on these two organizations. Thus, the pro- and anti- abortion movements are defined by the organization and activities of NARAL and the NRLC, respectively. Throughout this research the terms 'pro-abortion' and 'anti-abortion' will be used to refer to organized abortion supporters and opponents, respectively. Admittedly, members of both groups may take issue with these labels.

The Abortion Movements. The National Abortion Rights Action League (NARAL) is the national pro-choice lobbying organization and the largest national organization dedicated to preserving the right to safe and legal abortion for all women. Their primary target of influence is the Congress, but the organization also responds to judicial threats and community concerns. Organized in 1969 and called

the National Association for the Repeal of Abortion Laws (NARAL), this organization was active in leading the struggle to repeal abortion laws. Immediately after the 1973 decision, abortion opponents mobilized and introduced measures to over turn the Supreme Court decision. Staggenborg (1987) observed that "[t]he National Association for the Repeal of Abortion Laws changed its name to National Abortion Rights Action League (retaining the acronym, NARAL) after it became apparent that the battle over abortion would continue for some time" (p. 5). Before the year was over NARAL opened a lobbying office in Washington, D.C. (Staggenborg 1987, p. 5).

NARAL affiliates are located in 33 states. National NARAL concentrates on national legislation; whereas the state affiliates seek to influence legislation within the state and mobilize support of pro-choice people through various activities. Membership in the state chapters of NARAL is separate from the national organization.

In contrast to the simple structure of NARAL, the organization of the anti-abortion movement is more complex. The National Right to Life Committee (NRLC) was founded in 1973 and serves as the national umbrella organization for the Right-to-Life groups. The organization began as a loose coalition of small, local right-to-life groups, many affiliated with the Catholic Church, that eventually became the backbone of the movement. The Church provided financial resources as well as access to a secure base of voters. Together, the NRLC and the National Conference of Catholic Bishops (NCCB) comprised the Right-to-Life Movement (RTLM) in the early 1970's. The focus of the RTLM has been a constitutional amendment that would declare the fetus a 'human

person' from the moment of conception, "enjoying human rights, including the right to life" (Petchesky 1984, p. 261). By 1982, the relationship between NRLC and NCCB had dissolved. Continual battles within Congress often led to the deferment of the 'human life amendment' in favor of comprise proposals. To many in the NRLC, such compromises were unacceptable. Thus, the division between the NRLC and the NCCB "reflected a deepening in the anti-abortion movement between the practical need to win a victory and the ideological need to hold on to the 'human life amendment' as a goal" (Petchesky 1984, p. 261).

Mobilization. A turning point for both the pro- and anti-abortion movements was the passage of the Hyde Amendment in 1976, and enforced in 1977. In essence, the Hyde Amendment banned the use of Medicaid funds for abortion. The passage of this bill represented a success for the anti-abortion movement. For the pro-abortion movement, the new found success of the countermovement "caused an organizational expansion. . . new pro-choice organizations formed and existing organizations expanded their operations, taking advantage of the concerns raised" (Staggenborg 1987, p.7). Staggenborg takes issue with the belief that the pro-abortion movement demobilized in response to the 1973 Supreme Court victory. Because opponents of abortion immediately attempted to block implementation of the Supreme Court ruling via a 'human life amendment', there was no relaxation on the part of NARAL. Instead the political battle shifted from the judicial to the legislative arena. On the national level, the pro-abortion movement was in relatively good shape at the time of the passage of

the Hyde Amendment. However, by 1976 many of the state pro-abortion affiliates were not in a position to contribute anything to the movement. Unless the abortion issue was a threat within the state, most affiliates had all but dissolved due to decline in membership activity and/or change of leadership.

Once the Hyde Amendment was enforced, the tempo of the pro-abortion movement changed. On the national level the major pro-choice organizations increased efforts to protect abortion rights (Staggenborg 1987). In reaction to the passage of the Hyde Amendment, many organizations expanded their activities, such as National Organization for Women (NOW), Religious Coalition for Abortion Rights (RCAR), Zero Population Growth, and Planned Parenthood. In addition, new national and local reproductive rights organizations emerged, such as Committee for Abortion Rights and Against Sterilization Abuse (CARASA) and Reproductive Rights National Network (R2N2). The pro-abortion movement was comprised of a national network of organizations.

On the state level, NARAL affiliates were revived in response to attempts to restrict abortion. The atmosphere on the national level surfaced in state legislatures and a number of restrictive bills were introduced: restrictive standards of service delivery in newly formed abortion clinics, cutting off of state-funded abortions, and parental consent requirements on minors. State legislative threats "created renewed interest in the abortion issue among pro-choice constituents, despite an organization decline in the pro-choice movement" (Staggenborg 1987, p.9).

The passage of the Hyde Amendment significantly shifted the momentum of the abortion debate towards the anti-abortion side at the state and national levels in both the judicial and legislative branches (Conover & Gray 1983). The attack on legal abortion was part of the larger ideological transition toward conservative values and political goals. Abortion was taken up as the battering ram by an "ascendant New Right as the pivotal issue in a drive to impose conservative thinking on many arenas of policymaking and social life" (Petchesky 1984, p. 242).

In 1976 abortion emerged as an important issue in the Presidential campaign and became part of the Republican Party platform. By 1978, the anti-abortion movement was linked with conservative and 'new right' organizations (Jaffe et al. 1981). Petchesky (1984) characterized the relationship between the New Right and the anti-abortion movement as a symbiotic one; "the New Right organizers lend to the pro-life groups their expertise in direct mailing, targeting candidates, and managing PACs in return for securing a mass base of voters and local organizers" (p. 259). Although lured by the New Right, many anti-abortion leaders were hesitant to "let their single focus issue become absorbed into the larger 'profamily'/'proAmerica' agendas" (Petchesky 1984, p. 259). Petchesky (1984) observed that by 1981 "the initiative for legislative actions to stop abortion had clearly passed from the NRLC and the Catholic Church hierarchy to New Right politicians in Congress" (p. 261). Conflicts emerged between the New Right and the RTLM, with the New Right more interested in winning votes and trading favors and the anti-abortion movement

seeking a 'human life amendment'.

The defeat of the human life amendment campaign during the 1981-82 legislative sessions proved an upset for the alliance between the New Right and the anti-abortion movement, and a success for the pro-abortion movement. The defeat of the campaign also signaled the demise of the constitutional amendment strategy (Petchesky 1984). The failure of the campaign was due in part to the lack of unity between the New Right and the RTLM, and in part to the effective organization and mobilization of the pro-abortion movement. Once the hearings on the amendment proved problematic for the New Right, they began shifting their strategy to compromises and other right-wing issues, and therefore, removing their resources from the anti-abortion movement. The anti-abortion movement remained committed to the human life amendment, which gave their movement coherence and popular momentum (Petchesky 1984). Efforts continued, and pressures to limit abortion and to press Congress to pass a human life amendment were filtered through state legislatures.

Tactics. According to resource mobilization theory, the ability to convert a social movement's capacity to act into action depends on the movement's resources. Resources are allocated and actions are taken for the purpose of achieving or furthering the movement's goals. Social movements, therefore, need to determine what targets to influence and to formulate a general strategy of advocacy (Conover & Gray 1983). Thus, the tactics available and used by social movements influence their effectiveness. Below the tactics of the abortion movements are discussed in terms of their goals, resources, targets of

influence, and strategies of influence.

GOALS. The goals for the pro- and anti-abortion movements are clear and distinct. For the anti-abortion movement, their goal is the abolition of abortion, preferably via a constitutional amendment; whereas, the goal of the pro-abortion movement is to protect legal abortion. One group operates to change existing policy, while the other group acts to protect the existing policy. Both groups are contending for political power, and in such cases the government is typically the primary target of influence (Conover & Gray 1983).

RESOURCES. Membership is a primary resource available to both movements. Membership is an important resource, although it is an example of an intangible resource. It provides power, which can be gauged in terms of political effectiveness. One way a group obtains power is when its issues are addressed within the political arena, and consequently by legislative success.

Both movements claim a significant following. According to the 1980 edition of the Encyclopedia of Associations, NARAL's membership totaled 150,000, whereas the number of members in the NRLC was 12,000,000. Obtaining reliable membership data, however, is difficult (Conover & Gray 1983). Based on direct communication with the NRLC, it was found that the membership data was inflated. Whatever the total membership, while such social movements like the abortion movements may lack capital, they have an abundant amount of human labor and time (Conover & Gray 1983).

TARGETS OF INFLUENCE. For both groups the government is the primary target of influence. Anti-abortion groups concentrate on

Congress to pass abortion restrictions, whereas pro-abortion groups attempt to protect abortion rights. Anti-abortion groups target state legislatures to pass restrictions limiting abortion, and pro-abortion groups focus on state legislatures considering reform or repeal. In essence, the pro- and anti-abortion movements have adopted various targets to gain political influence and to affect public opinion.

STRATEGIES OF INFLUENCE. The three primary strategies used by the abortion movements are protest activities, lobbying and electoral activities. Protest activities are aimed at winning public support through demonstrations, speakouts and picketing. A significant trademark of the anti-abortion movement has been their constant presence at abortion clinics. Their various activities have ranged from peaceful protest to violent actions. In the mid-1970's, the pro-abortion movement organized 'speakouts' across the country where women spoke about the dangers and their emotional turmoil in obtaining illegal abortions. The purpose of these activities by the pro- and anti-abortion movements was to win over the bystander public.

Lobbying efforts are most often directed at state legislatures and involve testifying at hearings on various abortion bills. Conover and Gray (1983) found that testifying was not an effective means of winning supporters. Instead, such actions were seen as a major way of bringing the issue into the political arena.

Most forms of collective action used by the pro- and anti-abortion movements fall under the heading of electoral activities. It is well known that both movements devote large amounts of time, energy and money to defeating either pro-abortion or anti-abortion Congress

people. In the early days of the anti-abortion movement their strategies of influence were often targeted at the grassroots level. Abortion rights activists were more experienced politically than the antiabortion groups. On the national level, the anti-abortion movement needed to become more professional and meet the experience of the pro-abortion movement. However, on a state level, the pro-abortion movement needed to mobilize in order to counter the various local activities of the anti-abortion movement. It is difficult to describe the activities of the pro- and anti-abortion movements in comparable terms. Although the pro-abortion movement may have been more experienced politically than the anti-abortion movement, their developed skills could only be tested and evaluated when 'push came to shove' by the anti-abortion movement.

Political action committees (PACs) have been used to influence electoral activities by pro- and anti-abortion movements for direct political purposes. Set-up in 1977, PACs are organized committees whose purpose is to receive and disburse money to bring about specific political ends. The intent of these committees was to monitor and limit under law the amount of money political candidates could receive from outside sources. PACs also became a legal means by which social movement organizations could establish politically partisan funds without losing their non-profit status. PACs soon became the dominant vehicle for the abortion movements to financially support political candidates.

In summary, this brief examination of the tactics available to the pro- and anti-abortion movements shows that the two movements differ

in their goals, but have access to similar resources and direct the same strategies of action towards the same targets of influence. In general, social movements "challenge some group in power, often the state" (Langton 1987, p. 52). Challengers often find themselves constrained by the range of available options, whether it be the goals, access to resources or limited strategies of influence (Conover & Gray 1983). In this regard, the abortion movements differ from other social movements. Neither movement can be considered a challenger; "rather both movements seem to have access to the channels of influence usually open to 'members of the polity'" (Conover & Gray 1983, p.120).

Implications of Social Movement Activity for Abortion Services. Given the prominence of the pro- and anti-abortion movements it is important to ask to what extent have social movement activities had an impact on the availability of abortion services? Questions about the implications of social movement activities raise issues about the consequences of social movement activities in general, a topic not often discussed in the social movement literature. Furthermore, the consequences of social movement activities for policy outcomes are rarely discussed.

Since abortion is such a contentious issue, one would expect a plethora of research about the successes of the movements and the effects of various social movement activities. There are, however, individual case studies but few comparative state studies of the impact of social movement activity on abortion rates. For instance, questions asked have tended to focus on the effects of abortion

movements on the political system or the mass public, such as whether single issue groups tend to fragment the political system, or what effect a movement has on public opinion (Conover & Gray 1983). Other researchers have pointed out that the social movements have participation in the political process (Tatalovich & Daynes 1981, Jaffe et al. 1981).

The question addressed in this research is whether social movement activity affects policy outcomes; or, more specifically, whether abortion movement activity affects the availability and use of abortion services. A sociological perspective would suggest that social movements shape and change the social context in which they are embedded. Conover & Gray (1983) looked at the state level effects of New Right groups and feminist groups on the passage of the ERA and abortion restrictions. They found that the mobilization of feminist organizations had a greater impact on abortion legislation than the presence of New Right groups.

Abortion movement activity may help to explain state-to-state differences in the availability of abortion services. In states where the pro-abortion movement is strong, attempts may be made to keep abortion legal which would encourage the availability of services to all women. On the other hand, if the anti-abortion movement is effectively organized, then the effects of restricting abortions may pervade and discourage the availability of abortion services.

Lifestyle Differences and the Abortion Issue

The second factor is conceptualized as lifestyle differences. Many

components of this factor overlap with the social movement dimension. The difference between the two is that the social movement factor pertains to the effects of organized activities in relation to abortion services, whereas this second factor refers to the cultural considerations of the different positions. Abortion generates debates between sides, which "share almost no common premises and very little common language" (Luker 1984, p. 2). One explanation given is that the divisive nature of the debate reflects deeper religious, political and moral struggles between lifestyles. Callahan and Callahan (1984) described the conflict as symbolizing "the struggle between modernity and traditionalism" (p.220); and, Liu (1977) expressed the conflict as a clash "between those who cherish the traditional religious and moral values...against the tide of a more pragmatic and secular culture with different values" (p. 148). In this section it is argued that values which promote a particular cultural position can discourage or encourage the availability of abortion services.

The idea that the issue of abortion has symbolic value and meaning is supported by many researchers. However, often lacking is a theoretical basis for understanding abortion policy as symbolic. In this section the literature viewing abortion policy as a symbolic act is presented, an understanding of symbolic policy is developed, and a hypothesis based on the implications of the symbolic interpretation for the availability of abortion services is presented.

Abortion and the Symbolic Function of Politics. Viewing abortion policy as symbolic comes from an important tradition in political science which stresses the symbolic expressions and functions of

politics. Edelman (1964), in the book Symbolic Uses of Politics, examined political forms as symbolizing what citizens need to "believe about the state to reassure themselves" (p. 2). The individual derives identity through the state, and the actions of the state reaffirm "beliefs in fundamental rationality and democratic character of the system" (p. 17). Political forms serve to promote the acquiescence of the general public, and therefore generate social harmony. According to Edelman (1964), "every political institution and act evokes and reinforces responses in audiences" (p. 12). Therefore, institutions alone may stimulate threat or reassurance, regardless of what is said. For example, a population may approve a legislative decision, but dislike the manner in which the decision was reached and issued. In terms of the Supreme Court rulings on abortion, for many the involvement of the Court in the matter of abortion may have been reassuring, but the actual contents of the rulings were threatening. The act, therefore, can be seen as a threat to beliefs about the rational decision making process, and consequently upsetting the social order.

Similar to Edelman, Gusfield (1963) conceived of political acts as symbolic acts in the book Symbolic Crusade. Although both researchers agree that political acts have symbolic meaning, they differ in their approaches. For Edelman, the expressive value of political forms serves to maintain political arrangements. In contrast, Gusfield views political actions as symbolizing the position of groups in the status structure. In Symbolic Crusade, the role of the Temperance Movement was analyzed "as clashes and conflicts between rival social

systems, cultures and status groups" (p. 11). Gusfield's analysis of the issue of abstinence and the Temperance Movement serves as a frame for understanding the conflicts generated over the abortion issue. Arguments supporting and opposing abortion reflect the struggle between social groups vying for dominant position in the status structure. Members of a social group "share a distinctive system of values, customs and habits" (1963, p. 16). Therefore, a court ruling or passage of a law can be seen as affirming one group's values over another. Within this context, the symbolic importance of the 1973 Supreme Court decision was that it has been interpreted as affirming one set of values over another. The continual debate and legislative tensions since the 1973 court ruling reflect the ongoing battle for prestige and political power between these groups.

Symbolic Policy. Since research on symbolic policy as a type of policy is relatively undeveloped, any conceptualization of symbolic policy is a synthesis of the few available and appropriate research investigations. In general, policy research concentrates on economic concerns and the allocation of goods to a specific target population. Theodore Lowi (1964), well-known for his typology of economic policies, addressed the American experience of the policy process and classified policies according to outputs as either distributive, regulatory, or redistributive policies. Lowi's model has served as a framework for much policy research. Lowi's framework formed the basis for T. A. Smith's (1975) comparative study of public policies. Smith, however, noted that some policies are not necessarily concerned with economic disputes or have an economic impact. He classified such

policies as "emotive symbolic." According to Smith, "emotive symbolic policies. . . are types which generate emotional support for deeply held values, but unlike the other types [of policies]. . ., the values sought are essentially noneconomic" (p. 90). These emotive symbolic policies are concerned with issues of moral reform or embedded with moral controversy. Examples of issues which give rise to symbolic policies include abortion, the death penalty, desegregation in public schools, and prayer in public schools. Smith characterized emotive symbolic policies as including 1) intense levels of conflicts, cutting across various kinds of sociopolitical and economic groupings, 2) backbench leadership, in which non-leaders (some within government as well as special interest groups) "play a major role in the policy process" (p. 93), and 3) the breakdown of party discipline and the development of "legislative individualism" (p. 93).

Smith's emotive symbolic policy as a type of policy has several benefits. One advantage is that attention is drawn to a non-economic dimension of policy. Policy is often seen as an attempt to resolve conflicts based on economic or class divisions. Acknowledgment of non-economic based policies recognizes groups (divisions) identifiable by other than class elements. Another benefit is Smith's incorporation of groups and activities outside the immediate political structures directly associated with a given policy as having an important role in the policy process.

In contrast to Smith's concentration on policy formation, Jaros and Baer (1976) empirically investigated the outcome of symbolic policy in relation to citizen disaffection. Their conceptualization of symbolic

policy was based on Edelman's position "which stresses the importance of symbolic gratification rather than material reward in the promotion of political quiescence" (p. 580). The research showed that substantive policies are more important in determination of levels of political disaffection than symbolic policies. Jaros and Baer (1976) admitted that many kinds of policies offer "little in the way of services to the population at large" (p. 581). Instead, the significance of these policies lies in their conformity "to preferred values" which "symbolize the state of public morality" (p. 582). Such areas are frequently characterized by extreme controversy. According to Jaros and Baer (1976), the importance of a symbolic policy lies in its conformity "to citizens desires in certain areas" (p. 580). Symbolic policies provide approval for certain social values and morals, and therefore the dominance of these values is asserted in society. Thus, the Supreme Court decision can be seen as a judicial sanctioning of certain social values.

Symbolic Meaning of Abortion Policy. Abortion emerged as a symbolic issue in the late 1960's when the moral issues became manifest (Luker 1984). The modern debate is often constructed in terms of the moral status of the embryo, that is, whether or not the human rights should be attributed to the fetus. On one side of the debate, abortion opponents view the embryo as "the moral equivalent of the child it will become" (Luker 1984, p. 2). In contrast, abortion supporters uphold a distinction between the embryo and a child. But, is the conflict only about the moral status of the fetus, "or does it encompass other matters as well" (Joffe 1985, p. 26)? Many observers

would agree that there is more to the debate than fetal personhood. Luker (1984) stated that the abortion conflict involves ideas concerning the sanctity of life, "the place women should occupy in society, and about what the proper family structure should be" (p. xi). Similarly, Liu (1977) suggested that the abortion conflict reflected rapid social changes in two of the most traditional institutions - religion and the family. Using Gusfield's (1963) framework of status politics, Markson (1982) noted that the abortion decision reflected a "status threat . . . to those firmly committed to the traditional image of the family" (p. 30). Thus, the symbolic interpretation of abortion suggests that the arguments reflect a shorthand way of supporting and proclaiming "a complex set of values" (Luker 1984, p. 200). The groups differ in their world orientation and the roles of men and women in the structure of society.

Abortion opponents hold a fundamental orientation to the world, and maintain a traditional view of the family. Accordingly, abortion is intrinsically wrong because it means taking a life; "only God can create a man . . . and therefore only God has a right to destroy a man" (Merton 1981, p. 6). A fetus is seen as being entitled to the same rights as a person. Consequently, personhood is seen as "a 'natural', inborn, and inherited right" (Luker 1984, p. 157). Based on this view, it is not surprising that opponents regard parenthood as a 'natural' role, with men "best suited to the public world of work," and women "best suited to raise children" (Luker 1984, p. 160). Furthermore, the right to obtain an abortion gives "women control over their fertility; thus, upsetting "an intricate set of social

relationships between men and women that has traditionally surrounded women and children (Luker 1984, p. 162). On a general level, abortion foes reject the Supreme Court decision because they see abortion policy as an intrusion into an area where the state does not belong, namely, within the family.

In contrast, the moral position of abortion supporters can be described as a secular orientation rather than religious. A distinction is made between an embryo and the 'rights' of a child. Morality is not seen as obedience "to a set of inflexible rules . . ., but rather as the application of a few general ethical principles to a vast array of cases" (Luker 1984, p. 184). Furthermore, there is a firm grounding in the rights of individuals, and that "only individuals, not governments or churches, can ultimately make ethical decisions" (Luker 1984, p. 184). On the dimension of parenthood, abortion supporters view women's reproductive role and family roles as a social rather than a natural role. Motherhood is seen as one of several roles. Supporters tend to "believe that men and women are substantially equal" (Luker 1984, p. 176). However, within the organization of society, motherhood, "as long as it is involuntary, is seen as potentially a low-status" and unrewarding role (Luker 1984, p. 176). From their point of view, control over reproduction is seen as "essential for women to be able to live up to their full human potential" (Luker 1984, p. 176).

Implications of Lifestyle Differences for Abortion Services. Both sides represent distinct social orientations to the world. Abortion opponents hold to a world view of divine capacities, whereas abortion

supporters focus on human capacities and the capacity for reason (Luker 1984). As mentioned above, Gusfield (1963) defined social groups as members sharing a common "system of values, customs and habits" (p. 16). Abortion opponents and supporters are two groups whose values about the family and attitudes toward life differ significantly from one another. A sociological perspective suggests that the way people respond to abortion has to do with the cultural climate of their groups. Cultural conditions may give rise to pressures that would create and maintain abortion services. Therefore, differences in availability of services may be channeled by a particular cultural context (Linsky & Straus 1986). The lifestyle interpretation to abortion suggests that the cultural context of a state may help explain state-to-state differences in availability of abortion services. Groups whose values promote conventional views of marriage and maintain a fundamental religious orientation tend to oppose abortion, and therefore may discourage availability of services. On the other hand, groups whose values do not support traditional views of the family and religion often support abortion, and therefore may encourage the availability of services. It is expected that in states where the moral climate supports traditional values and style of life that fewer abortion services will be available.

Reproductive Rights: The Feminist Interpretation of Abortion

The third factor of reproductive rights differs from the social movement and lifestyle differences factors. The first two factors

examined the implications of conflicting positions on abortion for abortion services. This third factor places the abortion conflict in the larger context of reproductive rights for women. Within this framework, emphasis is placed on the relation between the status of women and the implementation of the Supreme Court decisions. Reproductive rights, or reproductive freedom, implies that women control the conditions in which decisions are made about childbearing, free from social, legal and economic coercion to childbearing (Gordon 1976). Safe and legal abortion is seen as essential for reproductive freedom and control.

Reproductive control is seen as a socially organized activity, rooted in the social relations between men and women. Within this context, the current abortion conflict is examined in terms of the existing social and economic position of women in society. Thus, the struggle for reproductive freedom is intimately connected to women's rights and cannot be viewed separately. The change in legal status of abortion is viewed as a response to changes in social and economic conditions that structure women's lives; i.e., work, marital patterns, birth control practices (Petchesky 1984).

Historically, abortion has not played a central role in women's struggle for reproductive freedom. Not until the early 1960's, when states separately began reforming 80 year old laws prohibiting abortion, did abortion emerge as a women's issue with an emphasis on women's control over reproduction (Luker 1984). In this section, the factors which lend themselves to understanding abortion as a women's issue are highlighted, a brief history of women's struggle for

reproductive rights is provided, and a hypothesis based on the feminist interpretation is presented.

Abortion as a Women's Issue. Prior to the mid 1900's abortion in most states had been legal, "or at worst a misdemeanor, if performed prior to quickening" (Petchesky 1984, p. 79). From the mid-19th century to the early 1960's the medical profession held the right "for assessing the conditional rights of the embryo against the woman's right to life" (Luker 1984, p. 35). The newly formed medical profession "led the campaign in the post Civil War days to criminalize abortion" (Petchesky 1984, p. 79). Their crusade against abortion was generated by two major demographic changes - a declining birth rate and a rising abortion rate among 'native' women, namely white, middle class women. According to Petchesky (1984), the push to criminalize abortion was motivated by the interests of the medical profession "to establish its monopolistic control over health care," and "to establish an ideological hegemony that would give them exclusive authority over their principle clientele - upper and middle class women" (p. 82). Opposition to abortion was built from several issues. As an organization, physicians opposed the doctrine of quickening on biomedical grounds, sought systematic regulation of lay competitors, and asserted the moral view that the fetus was a life. Thus, physicians controlled the technical expertise on which their judgments regarding the necessity of abortion were based, while women were excluded from any control in the decision making.

Over time improvements in obstetrical science combined with the decline of 'strictly medical conditions' contributed to the erosion of

the medical indicators for abortion. Within the medical profession consensus about deciding when an abortion was medically necessary began breaking down in the early 1960's: "physicians began to make abortion decisions that were perceived by their colleagues and the general public alike as less technical than moral" (Luker 1984, p. 77). Luker (1984) presented the argument that once differences of opinion among physicians emerged, the road was paved for other interest groups to vocalize their demands. At that time, abortion moved into its present status as a women's issue and was based on the claim that women have a right to control their own bodies.

The claim that women alone have the right to control their own fertility emerged during a time of significant social changes, the mid-1960's and early 1970's. For one, the social climate was hospitable "for intense social arousal and mobilization in all sorts of causes," especially civil rights (Luker 1984, p. 112). Traditional roles in general, and cultural expectations about women's roles specifically, were being questioned. Another significant social force was the expanded activities of women in the labor market. With more women entering the labor market, the "capitalist economy required reliable means of fertility control" (Petchesky 1984, p. 115). Within this favorable climate, the right to have control over reproduction was expressed and heard by women. However, while opportunities increased and women experienced greater economic independence, the responsibilities "of men, or of society as a whole, for the care and rearing of children have remained virtually unchallenged" (Petchesky 1984, p. 116). The slogan 'women's right to choose' is based on the

premise that women must decide whether or not to terminate a pregnancy because it is their bodies that are involved, and because women still have the primary responsibility for the care and the development of the children born (Petchesky 1980). Overall, feminists view the 1973 Supreme Court decision as progress toward securing basic freedoms for American women. However, some feminists also believe that the Supreme Court decision did not go far enough in "addressing existing social relations and sexual divisions around which responsibility for pregnancy and children is assigned" (Petchesky 1980, p. 670). They call "for social transformation that would expand individuals' abilities to genuinely choose to bear children - e.g. adequate health care, child care, income supports . . ." (Joffe 1985, p. 29).

History of Women's Struggle for Reproductive Freedom. A feminist perspective for understanding the struggle for reproductive rights is based on two assumptions. One assumption is that views about birth control occur within a definite social context of power relationships in our society. The second assumption is that shifts in fertility practices are in response to existing social and economic changes, rather than a determinant of these changes. Therefore, "the technology of birth control did not lead, but followed the social demand for it" (Gordon 1976, p. 274). In the book, Women's Body, Women's Rights, Gordon (1976) stated that "the high points of the birth control struggle in the past came with its maximum integration into larger political movements - the exploding 'women's movement' of the mid-nineteenth century and the Socialist party in the second decade of the twentieth century" (p. 414). The history of women's

struggle for reproductive rights is discussed below in relation to these two movements, with the focus on their similarities and differences. The purpose of this discussion is to provide an understanding of the historical basis and continuity of the ideas expressed in the modern abortion debate. Historically, the same arguments have been used in opposition to the changes advocated by each movement; namely, that changes in fertility control will 1) lead to sexual promiscuity, and 2) lead to the breakdown of the family. Both arguments can be heard today in the current struggle for abortion rights.

'Voluntary Motherhood' was "a slogan advanced by feminists in the second half of the nineteenth century" (Gordon 1976, p. xv). It expressed the emphasis on freedom, choice and autonomy for which women were unified in the movement. 'Voluntary motherhood' advocated women's right to choose when to have intercourse, and therefore when to bear children. Women believed that voluntary motherhood could be achieved through periodic abstinence either by means of mutual decision making or women's unilateral 'right to refuse'. Women were not advocating use of contraceptives. In the mid-nineteenth century, use of contraceptives was associated with sexual immorality. Birth control for voluntary motherhood advocates "had no other purpose than controlling their own childbearing" (Gordon 1976, p. xv). During the mid-nineteenth century, intercourse brought physical danger; frequent pregnancies, childbirth and abortion were all risky and painful. Therefore women had two choices, either to passively submit or to refuse. Voluntary motherhood was a significant feminist demand

(Gordon 1976).

Voluntary motherhood expressed a larger commitment to the principle of women's right to choose. Feminists then argued that since the worthiness of women depended on the integration of body and soul, it was essential to make professions open to women. They argued for increased rights and opportunities for women primarily because they were mothers. In order for women to be 'better' mothers, motherhood needed to be combined with other activities. Thus, the women's movement maintained a pro-motherhood ideology, with the goal of glorifying the task of mothering.

The women's movement of the 1870's, however, did not reject the institution of marriage, nor question traditional sex roles. Women needed marriage since they lacked economic independence. In fact, women depended on children to provide them with work. Thus, the intention of 'voluntary motherhood' was to give women recognition and dignity, as well as to provide a tool for women to strengthen their position within marriage.

In contrast, the birth control movement of 1910-1920, was part of a larger radical social movement which sought structural changes in society, especially gender and class relations. Educated radicals and the working class participated together in the struggle against capitalism, and creation of revolutionary demands to change their world. Since birth control was seen within the context of the overall power structure in society, the movement appealed to both men and women. The birth controllers of this period "considered men as well as women damaged by the subjection of women," and "lamented the

weakening of the whole working class by the inequalities within it" (Gordon 1976, p. xvii). Overlarge families were seen as weakening the participation of workers against class struggles. Lack of control over reproduction reflected unequal distribution of wealth (Gordon 1976). Reproductive freedom was seen as a means to alleviate the existing misery by creating greater sex and class equality.

The voluntary motherhood and birth control movement in the 1910's shared two characteristics. One, both movements occurred during a backdrop of similar demographic changes; a declining birth rate, and an increase in the number of smaller families. Second, neither movement sought to change the family structure. Such changes were seen as too threatening. Women still needed and depended on the institution of marriage, and economic and social discrimination held women responsible for children. Voluntary motherhood and use of contraceptives "helped married women to change power relations within their marriage" (Gordon 1976, p. 410). Once women could control when and whether to have children, then they could free themselves from the domination of men (Hymowitz & Weissman 1978).

The major difference between the two movements is in the public acceptance of the use of contraceptives. Acceptance of birth control in the second decade of the 1900's acknowledged the separation of sexuality from reproduction. Birth control at this time meant reproductive self-determination. In contrast, during the mid-nineteenth century, "such a separation was considered extremely immoral" (Gordon 1976, p. xi). The change in views about fertility control between the two time periods "required a major reorientation

of sexual values" (Gordon 1976, p. xi). Acceptance of birth control reflected changes in sexual morality that were both freeing and restricting for women. On the one hand, separation of sexuality from reproduction meant that sexual activity could be enjoyed for its own sake, as well as legitimation of female sexual pleasure. The change especially raised "the status and latitude of socially permissable activity for single women" (Gordon 1976, p. 410). However, use of contraceptives and change in sexual attitudes also provided greater freedoms for men as well as women. Often this new freedom was expressed in the form of rebellion against economic responsibility (Gordon 1976). Since economic and social discrimination held women responsible for children, desertion by men left women more vulnerable. Thus, birth control was important because of new sexual freedoms, and a necessity due to the impermanence of households.

In the 1970's, birth control emerged as a leading demand of the women's movement. The battle for reproductive self-determination "went along with the rediscovery of women's humanity in the struggle for total equality" (Gordon 1976, p. 410). Legalization of abortion has been the major achievement of the current movement. "But it is a shaky victory and the backlash against abortion is growing" (Gordon 1976, p. 415). The modern abortion debate has been built on the idea of individual rights, right to privacy, and the right to control one's body. All are important aspects in the effort to increase individual control over reproduction and are basic conditions for sexual equality. The fight for abortion rights is older and deeper than the issue of unwanted pregnancy or right to life.

Implications of Women's Struggle for Reproductive Rights for Abortion Services. There are two characteristics central to the reproductive rights of abortion. One is that reproductive freedom can not be separated from the totality of women's freedom (Gordon 1976). The second is that gender divisions and position of women in society have a direct and specific influence on fertility control practices, including abortion (Petchesky 1984). The reproductive rights dimension is a feminist view which emphasizes the concept of women's status.

In relation to abortion services, the central question is to what extent do structured gender inequalities shape the conditions which give rise to pressures that influence the availability of abortion services. Based on several empirical studies, Sugarman and Straus (1986) observed that "movement toward gender equality is most likely to take place in a highly educated affluent society, in which women have organized to promote their own welfare" (p. 17). Historically, it has been shown that the struggle for reproductive rights has been accompanied by women's struggle for independence. Therefore, if the position of women in society influences birth control practices, then it is expected that more abortion services will be available in states where women's status is relatively high.

Abortion Restrictions

In this section the relative importance of abortion restrictions for the availability of abortion services is examined. The factors discussed here in this section and in the following section differ

significantly from the first three factors already presented. Social movements, lifestyle differences, and women's struggle for reproductive rights all are conceptualizations of responses to abortion that were neither intended nor recognized as influencing the availability of abortion services. For example, one unintended consequence of the judicial ruling was the immediate mobilization of anti-abortion forces to overturn the judicial ruling. Although the pro-abortion movement existed before the 1973 Supreme Court decision, their effective use of strategies and resources were tested when provoked by anti-abortion movement activities. It is believed that responses to abortion by groups not directly involved with administrating the Supreme Court decision may affect the availability of abortion services. In contrast, the fourth factor examines the impact of abortion restrictions for abortion services, and the fifth factor looks at the structure and responsiveness of the health care system in relation to the availability of abortion services. Both of these factors focus on specific actions as responses to the Supreme Court decision and are direct attempts to deter the availability and use of abortion services. In this section, specifically, it is suggested that restrictions on abortion influence the availability of abortion services.

A major effect of legalization was to make abortion a safe and a legal service available to all women, especially poor women. Although the intent of the 1973 Supreme Court decision was to guarantee 'a woman's right to choose,' the reality was that abortion services did not become widely available. Prior to 1973 abortions "were performed

in a class-divided system that regulated poor women to sordid conditions of back-alley abortionists, while rich and middle class women usually had access to safe, sanitary abortions in hospitals and physician's offices" (Petchesky 1984, p. 156). When performed, abortions were monitored and limited through various hospital requirements and state regulations. And, if restrictions alone did not prohibit women from obtaining abortions, costs did.

After the Supreme Court announced its decisions on the two abortion cases, several efforts were launched to nullify the rulings. Legislation which sought to undermine or circumvent the intent of the 1973 rulings was overruled or modified by the Supreme Court. Eventually, however, efforts to limit abortion met with success in the form of the Hyde Amendment, passed by Congress in 1977, which restricts federal Medicaid funding of abortions.

The passage of the Hyde Amendment signaled a change in the abortion debate which seemed to favor and tolerate restrictions on legal abortions. This fourth conceptualization of the abortion debate considers regulations of abortion as an important factor affecting the implementation of the Supreme Court decision. Restrictions, especially economic ones like the Hyde Amendment, impose real limits on the use and availability of abortion services. The consequences of abortion restrictions are taken up in this section. First, attention is given to the various effects abortion regulations may have for women in need of services, followed by an examination of the Hyde Amendment and its consequences. In the final portion, a hypothesis based on the implications of abortion restrictions for the

availability of abortion services is stated.

Regulations. Since the 1973 Supreme Court rulings, legislation has been introduced at the local, state and national levels to regulate abortion. Although many laws have been struck down by the Supreme Court, the passage and enforcement of other regulations limiting abortion have been successful in imposing limits on abortion and abortion services, resulting "in the denial of basic abortion services to hundreds of thousands of women in need of legal abortion services" (Palley 1979, p. 131). Restrictions have limited abortions in 3 ways: through public funds, such as cuts in federal Medicaid funds for abortion; regulation of conditions under which abortion can be performed, such as informed consent requirements; and service restrictions, such as segregating abortion facilities and services from other family planning activities in federally funded clinics and hospitals (Petchesky 1984; Cates, Gold & Selik 1980).

Restrictions can also lead to fragmentation within the health care system. For example, limitations placed on existing services often lead to new services in order to meet the demand. The failure of many public hospitals to provide abortion created a demand which resulted in the rapid growth of a network of nonhospital abortion clinics to meet the needs of women. Furthermore, some restrictions offer economic incentives. If restrictions produce economic gains, then services which can benefit from the gains may be more likely to enforce new policies (Bond & Johnson 1982). Therefore, the decision whether or not to enforce regulations may be based on competitive forces in the medical market place, and not on need and demands of a

population.

Abortion regulations also have important health consequences. For example, the purpose of 'informed consent' requirements is "to provide more comprehensive information for women considering termination of pregnancy" (Cates et al. 1980, p. 617). In conjunction with various social and economic consequences, these restrictions can result in delays by women in obtaining abortions. Abortions obtained at later gestational stages add to the risk of complications that have been associated with adverse maternal health. The literature examining the health effects of abortion regulations have consistently shown that the gestational age of the fetus is an important variable in the morbidity and mortality associated with abortion (Cates et al. 1980). Thus, legislation seeking "to regulate abortion under the guise of ensuring adequate patient education and/or improving safety procedures can have opposite effects" (Cates et al. 1980, p. 620).

All the various regulations on legal abortion and their different consequences create a complicated reality. There is little doubt that abortion restrictions impose real limits for women in need of abortion services. Furthermore, the whittling away of abortion rights through regulations of either payments, services, or procedures affect women differently depending on class, race and age.

The Hyde Amendment. Passage of the Hyde Amendment was hailed as a success by abortion opponents for two important reasons. One, the legislation was a step in reaching the goal of abortion foes: to stop abortions. Second, states 'won back' the power taken away from them with the 1973 Supreme Court rulings. Prior to 1973, states could

determine abortion policy, and many legislators felt that if abortion were to remain a public issue, "then the state legislatures were the proper institution to set policy" (Tatalovich & Daynes 1981, p. 200). Also, several members of Congress viewed the Supreme Court's abortion decisions as an "attempt to interfere with their constitutional control over public finances" (Tatalovich & Daynes 1981, p. 186). Thus, with the passage of the Hyde Amendment, boundaries of public power in the state were defined and abortions were limited.

Until the introduction and enforcement of the Hyde Amendment in 1977, the Medicaid program subsidized abortion for low income women (Legge 1985). Medicaid is the major health assistance program for the poor. It is administered by the states under federal guidelines. The costs are shared, with the federal government paying 0% to 90% of costs for people who meet eligibility criteria (Jafee et al. 1981). Prior to the inception of the amendment, no one had determined how many abortions had been publically funded. Since then it has been determined that Medicaid eligible women in need of abortion services are disproportionately women of color, and "have an abortion rate that is three times higher than that of white, unmarried, middle- or working-class majority" (Petchesky 1984, p. 156). In essence, the Hyde Amendment was passed without "establishing any mechanism for examining the human consequences of its action or knowing how many women would be affected" (Trussell, Menken, Lindheim & Vaughan 1980, p. 130).

Since August, 1977, Medicaid funding has been restricted (Legge 1985). Between February, 1978, and February, 1980, coverage was

expanded and Federal funding of abortion was permissible in three circumstances: 1) in cases where pregnancy posed danger to the woman's life, 2) where pregnancy resulted from rape or incest, and 3) when continuation of pregnancy would result in severe and long-lasting physical damage (Legge 1985). Since May, 1981, guidelines have been restricted to permit funding only in circumstances necessary to save a woman's life.

Once federal funds for abortion were restricted, Medicaid eligible women were faced with three options with an unwanted pregnancy: 1) non-physician or self-induced abortion, 2) carrying pregnancy to term, or 3) delayed legal abortion (Gold & Cates 1980). Previous surveys had found that unmet need for abortion was disproportionately high among Medicaid eligible women before funding restrictions. With funds limited, it was predicted that the number of Medicaid eligible women in need of services would increase. Gold and Cates (1980) estimated "that between 5 and 90 excess deaths annually would occur as a result of funding restrictions" (p. 621).

Several investigations conducted after the enforcement of the Hyde Amendment found that despite the absence of federal or state funds, a majority of Medicaid eligible women were able to obtain abortions, primarily with a combination of personal funds and reduced clinic fees. Also, many states continued to fund medically necessary abortions (Gold & Cates 1980). Eighteen months after the enforcement of the amendment, Gold and Cates (1980) found that most low income women obtained abortions, that abortion related deaths did not increase as predicted, and that women obtained abortions at later

gestations than would have been expected. As mentioned before, any policy denying the abortion procedure increases the risks to the women of complications and deaths. Also, poor and minority women are the main ones to suffer such deaths and morbidity (Petchesky 1984). Thus it appears that Medicaid restrictions did not result in a return to back alley abortions, but some negative consequences remain.

Implications of Abortion Restrictions for Abortion Services. In this section it is argued that restrictions on abortion may be an important intervening factor in the implementation of the Supreme Court decision, and therefore may help explain state-to-state differences in availability of abortion services. State restrictions have concentrated on raising the costs of having or providing abortion, such as facility requirements, consultation by more than one physician, residence requirements, and limited use of public funds. Since regulations impose restrictions on services, it is expected that more services will be available in states which have fewer regulations limiting abortion and abortion services.

The consequences of abortion regulations were discussed, with an emphasis on the Hyde Amendment. The reason for focusing on the Hyde Amendment is that its passage paved the way for tolerating restrictions on legal abortions, and because its enforcement clearly points out the negative impact abortion regulations can have for women. To date, Congress' control over public funding remains its principle response to abortion. Cuts in Medicaid funding especially, effect poor states and low income women. Poorer states can not easily pickup the 90% federal portion of Medicaid for

abortions. Furthermore, most poor and minority women rely on outpatient services of government hospitals and clinics for their routine health care. With the elimination of public funds, low income women have difficulties paying for abortion at such establishments because medical costs have risen faster than other prices.

Role of the Health Care System

In this final section, abortion services are viewed as one more service provided by the health care system. So far the discussion of abortion has focused on politics, moral values and social conditions of women. However, the abortion procedure is a medical procedure and therefore availability of abortion services is dependent on the availability of health care facilities. A crucial aspect of the Supreme Court ruling was in framing the abortion decision as a medical decision. The Court ruling stated that the decision whether or not to terminate a pregnancy was between a woman and her physician. Another important aspect of the ruling was the elimination of institutional barriers which placed special requirements on abortion and abortion services which were not required of other health services (Palley 1979). The question being asked is what is the role of the health care system in the distribution of abortion services. Given that the Supreme Court ruling created a demand and determined the jurisdiction of that demand, it is suggested that the limitations on the availability of abortion services is similar to the limitations characteristic of many other health related services. In this section features commonly associated with availability of health care services

are extended to abortion services. An important feature of the health care system is its responsiveness to the population in need of various health care services. Since the health care system was given responsibility for the provision of abortion services, it may be assumed that the demand for abortion services along with the characteristics associated with the adequate provision of health care services would influence the distribution of abortion services in the United States.

There has been widespread support for the position that the health care system has an overshadowing effect on the availability of abortion services. Several researchers have tended to emphasize the limiting aspects of the health care system; that is, the "decisive influence of attending physicians on hospital abortion practices" (Petchesky 1984, p. 158; Jaffe et al. 1981). Other researchers, such as Lowenduski and Outshoorn (1986), have argued that the single, most important variable in the availability of abortion services is "the independent existence of a network of good medical facilities organized either by the state or in the private sector" (p. 4). Legge (1985) stressed that availability of abortion services shared the same problems as other health services; "questions of availability can not be considered alone without considering adequate level of medical services in general" (p, 127). In essence, these statements support a view of availability as constrained by the health care system, and that problems of availability are no different than constraints on the health care system in general. If so, then it is expected that the factors which affect availability of health care services in general

would also be important determinants of the distribution of abortion services.

According to Torrens (1978), several factors influence the diffusion of health services; the ability to deliver, which includes the characteristics of the health care system itself, the manner and attitude in delivery, and knowledge of the public's needs. In order to conceptualize the role of the health care system, this fifth factor is comprised of two dimensions: the characteristics associated the existence of health care facilities and the demand for care. Both of these dimensions are addressed in this section. First, the characteristics associated with the existence of health care services that may shape the delivery of services are discussed. Second, a profile of the women who use and want access to abortion services is provided. In the final portion, a hypothesis is presented based on the implications of the characteristics and responsiveness of the health care system for the availability of abortion services. It is suggested that together the two dimensions of this fifth factor influence the availability of abortion services.

Characteristics Associated with the Existence of Health Care Services. The ability to deliver services involves "characteristics of the relevant public and private infrastructures" and its utilization, such as "information, transportation, electricitiy, and water systems" (Brown & Philliber 1977, p. 215). In terms of existing hospitals, facility establishments for performing abortions were already in place. Hospitals could readily offer and perform the newly legalized procedure.

In this respect, the poor distribution of abortion services can be seen as a manifestation of the overall uneven distribution of health services. According to Legge (1975), the reasons that abortions are more accessible in urban areas that rural areas are the same reasons attributed to the availability of any other health services in rural areas: lack of medical practitioners and facilities. Similar to other health services, availability is "associated with more medical facilities and practitioners and a higher patient volume" (Legge 1985, p. 127). In contrast, Jaffe et al. (1981) claimed that the 'extraordinary' range in the distribution of abortion services "does not occur in the delivery of other health services (p. 16). According to their research, wide differences among women in different communities would have to exist in order to account for these differences.

The growth in number of services available steadily increased between 1973 and 1977. This consistent expansion of service availability can be interpreted as an initial response to the Supreme Court decision and a trend toward the expected pattern for the distribution of abortion services given that the demand for abortion is similar throughout the United States (Richards 1984). After 1976, growth in the number of services slowed down. Specifically, the distribution of hospitals performing abortions showed little change, while the number of non-hospital facilities increased. Lindheim (1979) showed that since 1976, the increase in services has been "attributable to the rapid growth of a network of non-hospital abortion clinics" (p. 283). Richards (1984) noted the relative

stability of established hospital facilities in relation to the climbing abortion rate, and explained the relationship in terms of "the response of social institutions to social change" (p. 149). He suggested that "any increased demand for services or products that is produced by a substantial social change as the Supreme Court decision is more likely to be met by new social institutions than by existing ones" (p. 150).

There are other reasons for the change in type of services that have to do with factors associated with general changes in the U. S. health care system. The 1970's and early 1980's can be characterized as an era of rapid rise in cost of health care with few constraints, and acceptance of the concept of 'equal access to health care' which depended on a strong federal government role. One consequence of the movement of federal funds to state and local governments was an increase in the inequality of health resources.

Free standing abortion clinics can be seen as an innovative adoption in response to an unmet demand. Establishment of new and innovative services is often a market decision and depends on several factors, including population potential, access and often monetary return (Henry 1978). Henry (1978) found that the distribution of abortion clinics in the northeast region of the United States followed "the hierarchical diffusion pattern evident for other technological innovations" (p. 8). That is, the initial establishments are in large urban regional centers, followed by wave like spread outward to smaller areas.

If it is assumed that the characteristics linked with a network of

health care facilities is a critical dimension in whether abortion services are available or not, then population and presence of existing medical facilities emerge as two important factors that may influence availability of abortion services. In the following section, the characteristics of the population in need of services are presented and discussed.

Demand for Care. The second dimension of abortion as a health care issue is the demand for care by those who are need of abortion services. Although several factors are related to availability and utilization of services, an ideal health care system should be directly responsive to the needs and views of the people served (Torrens 1978). Thus, the characteristics of the women in need should be important in determining availability of abortion services.

Between 1973 and 1980 the abortion rate steadily increased, and since 1981 the rate has "remained essentially stable" (Henshaw, Forrest & Blaine 1984, p. 119). The profile of women obtaining abortion during this time has remained fairly stable as well. Most abortions are obtained by women aged 15-29. Abortion rates (the number of abortions per 1,000 women aged 15-44) are highest among 20-24 year olds, followed by 15-19 year olds, and then 25-29 year old women. Rates drop off sharply with increasing age. The abortion rate among nonwhite women has been about twice that among whites, but the proportion of the total abortion obtained has been consistently higher among whites than nonwhites. Between 1974 and 1980, over 70% of abortion were obtained by unmarried women. In regard to education, the Alan Guttmacher Institute reported that "[W]omen of all

educational levels use abortion services" (Henshaw & O'Reilley 1983, p. 10). Generally, it is believed that less educated women are in need of services since they may not have access to information and are less likely to have access to abortion through a private physician. In summary, the general characteristics of users of abortion services are young, nonwhite and unmarried women. Although many women are denied access, abortion is much easier to obtain than before 1973.

Implication of Abortion as a Health Care Issue for Abortion Services. The fifth factor focused on two assumptions. One, is that the characteristics associated with the existence of health care facilities are a critical dimension of whether services are available or not. The second assumption is that the demand for care influences the diffusion of abortion services, which is similar to the responsiveness of other health related services. The common theme apparent in both of these assumptions is the role attributed to the health care system which in turn may constrain the availability of abortion services. How and by whom services are provided is a critical aspect of whether services are available. If it is assumed that the health care system has a significant role in determining availability of services, then characteristics associated with the existence of health care services, such as urban population and availability of physicians; and characteristics of the population demanding the service, such as race, education, proportion of unmarried women, and proportion of females of childbearing ages present in a population may explain state-to-state differences in the availability and utilization of abortion services.

Summary of Interpretations

One approach to understanding the distribution of abortion services is to examine the consequences of abortion policy as potential factors that may influence the availability of abortion services. In this chapter, five types of factors reflecting various aspects of the current abortion issue were discussed and hypothesized as influencing the location and distribution of abortion services. The view that the issue of abortion is shaped by the mobilization and activities of pro- and anti-abortion movements is reflected in the social movement perspective. The lifestyle interpretation suggests that the controversy surrounding abortion is a moral protest to protect and promote a particular cultural position. Feminists, on the other hand, view the struggle for abortion rights as part of the on-going battle for reproductive self-determination and as a reflection of the social relations between women and men. Another position suggests that restrictions limiting abortion have an effect of influencing abortion demand or performance. And, the final interpretation suggests that regardless of the social and political context of the current abortion debate, the existence of a network of health care services, along with the demand for abortion determines the availability of abortion services. These positions are not mutually exclusive, and they share several overlapping elements. For instance, the pro-abortion movement embodies part of the feminist perspective of the abortion issue as the struggle for reproductive rights. The difference between the two is that the social movement perspective views the organized activities of

the social movements as influencing the availability, where the reproductive rights position reflects an ideology based on existing social relations. These five factors are operationalized in Chapter 4, and will be analyzed in order to discover whether these factors separately or together in some combination influence the distribution of abortion services in the United States.

Chapter 4

MEASUREMENT OF ABORTION SERVICES AND DIMENSIONS OF THE ABORTION ISSUE

This chapter describes the variables used to test the implementation model of abortion services. Ordinary least squares (OLS) regression analysis will be used to test the model for separate years (1976 & 1982), with the American states as the units of analysis (N=50). A weighted regression analysis will be used to test a pooled cross-sectional and time series model of this data (N=100). This chapter is divided into three sections. In the first section, the use of states as units of analysis is discussed. The other two sections provide descriptions of the indicators used in this study to operationalize abortion services (the dependent variables) and the five dimensions of the abortion issue (the independent variables).

STATES AS UNITS OF ANALYSIS

This research focuses on the availability of abortion services in the American states. The state as a unit of analysis is appropriate for the purposes of this research for several reasons.

First, states are a theoretically appropriate unit of analysis for the study of abortion. Historically, abortion has been confronted on a state level. During the 1800's, the status of abortion was regulated by laws introduced and enforced at the state level. These

state level anti-abortion laws remained in effect until the 1960's when several states began reforming or repealing their existing anti-abortion laws. In fact, the 1973 Supreme Court decision "dramatically accelerated . . . the inevitably slow, uneven process of revision on a state-to-state basis" (Mohr 1978, p. 260). The 1973 Supreme Court decision transferred power away from the states with regard to abortion during the first trimester of a woman's pregnancy. However, during the second and third trimesters, state laws could set standards for abortion procedures in order to protect the health and safety of the mother. Between 1973 and 1976 states unsuccessfully struggled against their loss of power by initiating various pieces of legislation attempting to regulate abortion, such as consent and residency requirements. However, the states' success was achieved in 1977 with the passage of the Hyde Amendment. States could determine under what conditions state medicaid funds would pay abortion expenses. As mentioned in Chapter 3, the passage of the Hyde Amendment signaled a change which promoted an atmosphere that favored and tolerated restrictions on legal abortion. Within certain limits, states could once again initiate regulations to restrict abortions.

A second reason for using state level data concerns the structure of the American health care system. Since the 1970's states have become involved in a wide variety of health services. During the early 1970's more and more federal funds were transferred to state and local governments with as few federal strings as possible (Lee & Estes 1983). Thus, the states gained legal authority for a wide range of health care programs (Clarke 1981). For example, states are

responsible for licensing health care facilities and abortions must be performed in a licensed facility. Other areas of responsibility which may affect availability of abortion services include regulating the sale of health insurance, paying for health services for the poor, providing health services directly, and regulating cost in some fashion or another (Clarke 1981).

The third reason is that there is an established precedent for the study of policy in the 50 states by social scientists, especially political scientists. States are meaningful units for policy research since they "are often the initiators of legislation and programs and are frequently the unit of implementation of federal policies" (Yllo 1980, p. 58). For example, political scientists have been interested in testing propositions regarding the determinants of variation in policy outputs. This literature has focused on whether broad socioeconomic influences or a narrowly defined set of political characteristics are of greater influence in accounting for state policy outputs (Lindeen & Willis 1975). In the case of abortion, policy responsibility rests primarily with the states which can impede or facilitate implementation of Supreme Court decisions (Hanson 1980). Therefore, it seems reasonable to expand the study of policy variation in outputs to variation in implementation and begin testing propositions regarding implementation of policies, especially abortion policy.

The availability of state level data is important to social science research in that many theories can be tested readily with state data, whereas other data may be too costly or difficult to obtain. State

level data have often been collected over time. For abortion research, an abundance of state level data are available through the Alan Guttmacher Institute and the federal Centers for Disease Control. Since 1973, both institutes have continued to collect and analyze information about abortion needs, services and policies on a state level. The availability of these data, as well as any state data, over time allows for historical investigation and performance of time series analyses and cross-lagged correlation analyses. Time series analysis enables social scientists to establish more clearly causal inferences (Straus & Jaffee 1985).

ABORTION SERVICES

The dependent variables in this study are two measures of abortion services: the abortion rate, a measure of the number of abortions obtained by state residents per 1,000 women aged 15-44; and, the provider rate, indicated by the total number of abortion providers within the state per 100,000 women aged 15-44. The referent years for the dependent variables are 1976 and 1982, with the 1982 abortion rate and provider rate based on the population of women aged 15-44 in 1980. The data on abortion services were made available by the Alan Guttmacher Institute.

Abortion services refers to two important dimensions of availability - the utilization of abortion services (abortion rate) and the availability of abortion providers (provider rate). For the

remainder of this dissertation, either abortion rate or provider rate will be specified when discussing the availability of abortion services.

The frequency distribution for the provider rate and abortion rate differ from one another, each showing a great deal of state-to-state variation. Table 4.1 shows the means, standard deviations and value ranges for the 1976 and 1982 abortion rates and provider rates. The state ranks for these variables are listed in Table 4.2 and Table 4.3.

Descriptive statistics

Abortion rates vary widely among states. The mean abortion rate across states rose from 19.4 to 23.9 between 1976 and 1982, while the standard deviation increased slightly from 8.1 to 8.5. Although the abortion rate increased between these two years, the pattern of the distribution did not change much. The overall shift in the abortion rate suggests that abortion has gained social acceptance. In 1976, the abortion rate ranged from a low of 9 or less per 1,000 women of childbearing age in Idaho and Mississippi, to a high of 38.8 in California and 38.0 in New York. By 1982, the lowest value was 11 abortions per 1,000 women in South Dakota, North Dakota, Utah and Kentucky. In 1976 and 1982, the states with low abortion rates are predominately rural states, which may be attributable to inadequate abortion providers. California and New York remained the two highest ranking states with values of 44.5 and 42.6, respectively. In addition to California and New York, the states with the highest abortion rates were Maryland (40.4), Nevada (40.3), New Jersey (38.3) and Hawaii (37.6). In general, abortion rates are higher on the East

TABLE 4.1 Descriptive Statistics of Abortion Services.

LABEL	YEAR	MEAN	STD DEV	MINIMUM	MAXIMUM
ABORTION RATE	1976	19.42	8.09	8.10	38.80
ABORTION RATE	1982	23.93	8.55	11.20	44.50
PROVIDER RATE	1976	5.29	3.63	0.71	15.54
PROVIDER RATE	1982	5.95	4.37	1.30	22.13

TABLE 4.2 State Ranks for 1976 and 1982 Abortion Rates.

STATE	ABORTION RATE 1976	STATE	ABORTION RATE 1982
CALIFORNIA	38.80	CALIFORNIA	44.50
NEW YORK	38.00	NEW YORK	42.60
MARYLAND	36.90	MARYLAND	40.40
NEW JERSEY	33.30	NEVADA	40.30
MASSACHUSETTS	30.20	NEW JERSEY	38.30
WASHINGTON	30.10	HAWAII	37.60
ILLINOIS	29.50	CONNECTICUT	33.70
FLORIDA	29.10	FLORIDA	33.50
NEVADA	27.90	MASSACHUSETTS	31.20
DELAWARE	27.60	WASHINGTON	31.00
HAWAII	27.40	COLORADO	30.20
VIRGINIA	26.50	MICHIGAN	28.50
CONNECTICUT	25.50	VIRGINIA	28.30
OREGON	23.60	RHODE ISLAND	28.30
MICHIGAN	22.30	NEW MEXICO	27.30
COLORADO	21.90	TEXAS	27.00
OHIO	21.80	GEORGIA	26.80
PENNSYLVANIA	21.40	DELAWARE	25.50
GEORGIA	20.40	ILLINOIS	25.10
TEXAS	20.20	OREGON	25.00
TENNESSEE	20.00	VERMONT	24.20
VERMONT	20.00	PENNSYLVANIA	24.00
RHODE ISLAND	19.20	OHIO	23.80
NEW MEXICO	18.70	ARIZONA	23.50
NORTH CAROLINA	18.40	NORTH CAROLINA	23.00
ALASKA	17.40	LOUISIANA	22.60
KANSAS	17.20	SOUTH CAROLINA	22.50
MISSOURI	16.30	ALABAMA	22.10
WYOMING	15.80	OKLAHOMA	21.40
ARIZONA	15.70	NEW HAMPSHIRE	20.90
MINNESOTA	15.40	MAINE	20.90
WISCONSIN	14.90	ALASKA	20.70
SOUTH CAROLINA	14.20	TENNESSEE	20.50
INDIANA	14.10	MISSOURI	20.00
NEW HAMPSHIRE	13.90	WISCONSIN	19.50
ARKANSAS	13.00	WYOMING	19.30
OKLAHOMA	13.00	MONTANA	18.30
KENTUCKY	12.80	KANSAS	17.80
IOWA	12.60	MINNESOTA	17.70
MONTANA	12.50	ARKANSAS	16.00
MAINE	12.00	INDIANA	15.80
SOUTH DAKOTA	11.70	NEBRASKA	15.70
NORTH DAKOTA	11.20	IDAHO	15.30
WEST VIRGINIA	11.10	IOWA	14.20
ALABAMA	10.90	MISSISSIPPI	13.60
NEBRASKA	10.90	WEST VIRGINIA	12.10
LOUISIANA	10.40	SOUTH DAKOTA	11.80
UTAH	9.20	NORTH DAKOTA	11.60
IDAHO	8.20	UTAH	11.30
MISSISSIPPI	8.10	KENTUCKY	11.20

TABLE 4.3 State Ranks for 1976 and 1982 Provider Rates.

STATE	PROVIDER RATE 1976	STATE	PROVIDER RATE 1982
HAWAII	15.54	HAWAII	22.13
VERMONT	15.24	VERMONT	15.45
NEVADA	13.38	MAINE	15.36
WASHINGTON	11.82	ALASKA	13.28
CALIFORNIA	10.42	NEVADA	12.82
NEW MEXICO	10.26	MONTANA	10.99
COLORADO	9.94	CALIFORNIA	10.22
NORTH CAROLINA	9.45	COLORADO	9.95
OREGON	8.61	WASHINGTON	9.66
ALASKA	8.14	OREGON	9.65
MAINE	7.96	NEW MEXICO	8.37
NEW YORK	7.48	NEW HAMPSHIRE	8.23
WYOMING	7.14	NORTH CAROLINA	8.17
ARIZONA	6.27	NEW YORK	7.38
MASSACHUSETTS	6.24	WYOMING	7.18
FLORIDA	6.15	IDAHO	6.98
MONTANA	6.06	FLORIDA	6.80
PENNSYLVANIA	5.83	CONNECTICUT	6.39
CONNECTICUT	5.60	VIRGINIA	6.19
KANSAS	5.12	GEORGIA	6.18
IDAHO	5.03	ARIZONA	5.92
DELAWARE	4.51	NEW JERSEY	5.92
TENNESSEE	4.45	MASSACHUSETTS	5.70
NEW JERSEY	4.28	ALABAMA	5.01
TEXAS	4.24	MARYLAND	4.99
IOWA	4.13	DELAWARE	4.87
NEW HAMPSHIRE	3.87	TENNESSEE	4.36
GEORGIA	3.85	KANSAS	4.34
MARYLAND	3.75	PENNSYLVANIA	4.32
NEBRASKA	3.75	IOWA	3.85
ILLINOIS	3.54	MICHIGAN	3.79
MICHIGAN	3.35	TEXAS	3.78
ALABAMA	3.34	MISSOURI	2.79
VIRGINIA	3.16	WISCONSIN	2.68
SOUTH CAROLINA	2.88	OKLAHOMA	2.63
ARKANSAS	2.76	ARKANSAS	2.59
UTAH	2.55	INDIANA	2.34
MINNESOTA	2.40	RHODE ISLAND	2.32
KENTUCKY	2.28	WEST VIRGINIA	2.32
OKLAHOMA	2.25	MISSISSIPPI	2.28
RHODE ISLAND	2.07	NEBRASKA	2.26
MISSOURI	2.07	OHIO	2.20
MISSISSIPPI	2.02	ILLINOIS	2.18
WISCONSIN	1.98	MINNESOTA	2.09
WEST VIRGINIA	1.88	NORTH DAKOTA	2.06
OHIO	1.77	UTAH	2.06
LOUISIANA	1.63	SOUTH CAROLINA	2.00
INDIANA	1.61	LOUISIANA	1.80
NORTH DAKOTA	1.48	SOUTH DAKOTA	1.33
SOUTH DAKOTA	0.71	KENTUCKY	1.30

and West coasts than the interior states.

Table 4.1 shows that between 1976 and 1982 the mean provider rate increased slightly from 5.2 to nearly 6.0 providers per 100,000 women aged 15-44, and the standard deviation increased from 3.6 to 4.4. In 1976, South Dakota was the only state with less than 1 provider for 100,000 women. Other states with relatively low provider rates were Wisconsin (1.98), West Virginia (1.88), Ohio (1.77), Louisiana (1.63), Indiana (1.48) and North Dakota (1.48). Except for Wisconsin and Ohio, these are predominately rural states. By 1982, all 50 states had at least one provider per 100,000 women of childbearing age, and only three rural states had fewer than 2 providers - Louisiana, South Dakota and Kentucky.

The slight increase in the 1982 mean provider rate could be attributed to the extreme value of Hawaii. In 1976, Hawaii and Vermont had similar provider rates of at least 15 providers per 100,000 women. By 1982, the rate of providers increased to more than 22 providers, while Vermont's provider rate increased slightly from 15.24 to 15.45. One explanation for the high provider rate in Hawaii is the geographic separation from the mainland. Since women in need of abortion cannot easily travel to a neighboring state to obtain the abortion, it is possible that more pressure within the state is created to provide the needed services. Other states with relatively high provider rates were Nevada, Washington, California and New Mexico (1976), and Maine, Alaska, Nevada, Montana and California in 1982. Except for Vermont and Maine, the country's highest provider rates occurred in the Western states.

In general, the provider rates showed little change between 1976 and 1982, in comparison to the abortion rate. One explanation is a change in the type of settings providing services. In 1976, most procedures were performed in hospitals. Over the years, there has been a major shift of abortion from hospitals toward nonhospital facilities (this trend is further discussed in Chapter 7), and a shift from hospital inpatient to outpatient procedures (Henshaw, Forrest and Blaine 1984). Furthermore, insurance companies have become more restrictive in their coverage of abortion procedures" (Henshaw, Forrest and Van Wort 1987). Movement away from the hospital setting may have been accompanied by an increase in the number of procedures performed by nonhospital facilities. Nonetheless, the geographic distribution of abortion services continues to be uneven.

Summary

The descriptive results indicate a large amount of variation among states on both the abortion rates and provider rates. It is difficult to pin-point a consistent pattern that would summarize the variation. Some general observations based on the descriptive information include: 1) California and New York showed high abortion rates but did not rank high on provider rates, 2) large Western states consistently had high provider rates, 3) abortion rates are highest on the East and West coasts, and 4) states with relatively low abortion rates and provider rates were predominately rural states.

Examination of the frequency distribution and state rankings show an uneven geographic distribution of abortion providers and widely varying state abortion rates. This suggests that factors related to

the utilization of abortion services may be different from factors related to the availability of those providers. Results from the regression analysis will help determine the effects of the different components on abortion rates and provider rates.

FIVE DIMENSIONS OF ABORTION

The referent years for the independent variables are primarily 1976 and 1980. In 1976 the U. S. Census Bureau published a special summary report profiling the social and economic characteristics of individual states. This document made it possible to locate data to measure and test the effects of the social and political factors on the 1976 abortion rate and provider rate. However, the same convenience did not hold for locating similar variables needed to predict the 1982 abortion rate and provider rate. When available, 1982 data were used. If not available, then 1980 census data were used to measure the various components. Special consideration was given to assure that the data dates of the predictor variables preceded the referent years of the dependent variables. The dates of the data used are included with the description of each indicator. The descriptive statistics for the variables used to measure the five factors are displayed in Table 4.4.

The data for the independent variables were primarily obtained from the State and Regional Indicators Archive (SRIA) at the University of New Hampshire. The SRIA houses a vast array of data on the social and

Table 4.4 Descriptive Statistics for Independent Variables.

LABEL	DATES	MEAN	STD DEV	PREDICTED RELATIONSHIP
Social Movements				
ANTI-ABORTION MOVEMENT ACTIVITY	82	0.51	0.51	-
PRO-ABORTION MOVEMENT ACTIVITY	82	0.18	0.39	+
Lifestyle Differences				
RELIGIOUS ORIENTATION INDEX	76	0.00	0.47	-
RELIGIOUS ORIENTATION INDEX	80	0.01	0.46	-
PERCENT FAMILIES WITH CHILDREN	76	54.18	3.13	-
PERCENT FAMILIES WITH CHILDREN	80	52.42	3.24	-
DIVORCE RATE	76	5.49	2.31	+
DIVORCE RATE	80	5.66	2.25	+
PERCENT WOMEN IN LABOR FORCE	76	54.98	4.41	+
PERCENT WOMEN IN LABOR FORCE	82	53.60	4.43	+
Status of Women				
STATUS OF WOMEN INDEX	76	-0.06	0.58	+
STATUS OF WOMEN INDEX	82	-0.05	0.58	+
Abortion Restrictions				
TOTAL ABORTION RESTRICTIONS INDEX	73-75	9.72	9.47	-
Role of Health Care System				
Characteristics				
PHYSICIAN RATE	76	152.83	40.10	+
PHYSICIAN RATE	82	171.60	42.75	+
PERCENT METROPOLITAN	76	58.31	25.26	+
PERCENT METROPOLITAN	80	61.37	22.85	+
Demand for Care				
PERCENT BLACK	76	8.95	9.28	+
PERCENT BLACK	80	9.14	9.22	+
PERCENT NOT MARRIED FEMALES 14+	76	39.84	1.95	+
PERCENT NOT MARRIED FEMALES 15+	80	43.38	3.40	+
PERSONS 18+YRS: MDN SCHL YEARS COMPLTD	76	12.47	0.18	-
PERSONS 25+YRS: MDN SCHL YEARS COMPLTD	80	12.48	0.19	-
PROPORTION OF FEMALES 15-44 PER 1K POP	76	0.22	0.10	+
PROPORTION OF FEMALES 15-44 PER 1K POP	80	0.23	0.01	+

economic characteristics of the American states available from diverse sources. Several of the variables used in this study were already available in the SRIA. Indicators, such as abortion restrictions, were especially added for this study and have since become a permanent part of the archive.

Social Movements

It is a difficult task to measure the level of mobilization and organization of the pro- and anti-abortion movements. While size of membership would be an obvious choice, solicitation of these groups produced little information about membership on a state level. For the most part, organizations such as National Abortion Rights Action League (NARAL) and National Right to Life Committee are reluctant to provide membership information. Furthermore, Conover and Gray (1983) claimed that membership data may not be reliable. They found that nationwide membership information by several organizations are inflated.

Social movement activity is measured by a content analysis of articles reporting social movement activity referenced in NewsBank in 1982. A measure of social movement activity in 1976 is not included. NewsBank is a current affairs reference service that provides access to articles from the newspapers of over 450 cities in the U.S. Publications from cities in all 50 states are used in its products. Entire articles of research value are selected from the newspapers and reproduced on microfiche. Articles meeting NewsBank's criteria of content and subject significance are selected by trained specialists. The articles are selected from major fields, including social, health,

legal, political, international, economic and scientific areas.

There are two major limitations in the use of newspaper articles for assessing social movement activity. One, the news coverage may be biased depending on the political orientation of the newspaper publishers. Second, the events included may be 'out of the ordinary' stories. In other words, demonstrations at abortion services may be a regular event, and become newsworthy only when something unusual happens. The articles, therefore, would reflect 'sensational' social movement activity of the pro- and anti-abortion movements.

The following procedure was used to obtain two variables: pro-abortion movement and anti-abortion movement activity. 1. In the NewsBank Index, entries listed under the general heading 'abortion' and the specific headings 'protests', 'demonstrations', and the names of anti- and pro-abortion movements were used for the analysis. 2. I retrieved the microfiche files and read the referenced articles. 3. A state was given a mark for pro- abortion movement and/or anti-abortion movement based on the location of the activity and type of movement. 'Type' of movement refers to type of groups(s) involved in the article, that is, pro- or anti-abortion movements. For example, an article about clinic harassment by anti-abortion demonstrators in Granite City, Illinois, counted as anti-abortion movement activity in Illinois. If several articles referenced the same activity, the appropriate movement variable for the state was given only one mark. Therefore, the activity was counted and not the number of times an activity was reported. 4. If an article mentioned social movement activity in another state, then the referenced state was given a mark.

5. State anti-abortion movement and pro-abortion movement scores were computed by adding the number of activities by each group in a given state. Therefore, the higher the score, the more pro- and anti-abortion movement activity in a state.

The results from the content analysis revealed that using raw counts for the two variables was less than ideal. Table 4.5 shows how the states ranked on the anti- and pro-abortion movement variables. For anti-abortion activity, the scores ranged from 0 to 7, with over 90% of the states having a value between 0 and 2. The four states with a count of 3 and above are Illinois (3), Florida (4), New Jersey (5), and Missouri (7). The range of values for the pro-abortion movement activity variable was smaller than the range for the anti-abortion movement variable, and the distribution was highly skewed. Over 90% of the states had a value of 0 or 1, with 41 states having a count of 0. Illinois, New Jersey, and Missouri all had high counts of pro-abortion movement activity, as well as anti-abortion activity.

Since the raw data were so skewed, a dummy variable for anti-abortion movement and pro-abortion movement activity was created. The dummy variable for anti-abortion movement activity was created by giving a state a value of 0 for no anti-abortion activity, and a 1 for any anti-abortion movement activity. Similarly, the dummy variable for the pro-abortion variable was based on no pro-abortion activity (0) and any pro-abortion activity (1). The distribution for the anti-abortion movement dummy variable shows that 24 states have a value of 0, and 26 states have a value of 1. The distribution for the pro-abortion variables is not as evenly distributed; 41 states have a

TABLE 4.5 State Ranks for Social Movement Activity in 1982.

STATE	ANTI-ABORTION	STATE	PRO-ABORTION
MISSOURI	7	MISSOURI	2
NEW JERSEY	5	NEW JERSEY	2
FLORIDA	4	ILLINOIS	2
ILLINOIS	3	COLORADO	2
COLORADO	2	FLORIDA	1
KENTUCKY	2	LOUISIANA	1
WISCONSIN	2	NORTH DAKOTA	1
ALABAMA	1	PENNSYLVANIA	1
ARIZONA	1	TEXAS	1
CALIFORNIA	1	KENTUCKY	0
HAWAII	1	WISCONSIN	0
IDAHO	1	ALABAMA	0
LOUISIANA	1	ARIZONA	0
MAINE	1	CALIFORNIA	0
MARYLAND	1	HAWAII	0
MICHIGAN	1	IDAHO	0
NORTH DAKOTA	1	MAINE	0
OHIO	1	MARYLAND	0
PENNSYLVANIA	1	MICHIGAN	0
RHODE ISLAND	1	OHIO	0
SOUTH CAROLINA	1	RHODE ISLAND	0
SOUTH DAKOTA	1	SOUTH CAROLINA	0
TEXAS	1	SOUTH DAKOTA	0
VERMONT	1	VERMONT	0
VIRGINIA	1	VIRGINIA	0
WASHINGTON	1	WASHINGTON	0
ALASKA	0	ALASKA	0
ARKANSAS	0	ARKANSAS	0
CONNECTICUT	0	CONNECTICUT	0
DELAWARE	0	DELAWARE	0
GEORGIA	0	GEORGIA	0
INDIANA	0	INDIANA	0
IOWA	0	IOWA	0
KANSAS	0	KANSAS	0
MASSACHUSETTS	0	MASSACHUSETTS	0
MINNESOTA	0	MINNESOTA	0
MISSISSIPPI	0	MISSISSIPPI	0
MONTANA	0	MONTANA	0
NEBRASKA	0	NEBRASKA	0
NEVADA	0	NEVADA	0
NEW HAMPSHIRE	0	NEW HAMPSHIRE	0
NEW MEXICO	0	NEW MEXICO	0
NEW YORK	0	NEW YORK	0
NORTH CAROLINA	0	NORTH CAROLINA	0
OKLAHOMA	0	OKLAHOMA	0
OREGON	0	OREGON	0
TENNESSEE	0	TENNESSEE	0
UTAH	0	UTAH	0
WEST VIRGINIA	0	WEST VIRGINIA	0
WYOMING	0	WYOMING	0

score of 0 and 5 states have a value of 1.

One of the purposes of the anti-abortion movement is to stop abortions. It is thus hypothesized that in states in which anti-abortion movement activity is present, there is a lower abortionrate and fewer providers available. In states with visible pro-abortion movement activity, attempts may be made to help keep abortion legal which would encourage the availability of services to all women. Both dummy variables will be used in the implementation model tested in Chapter 6.

Lifestyle Differences and the Abortion Issue

Two aspects of lifestyle differences are highlighted by measures of religion and the family. Two measures of religion are used to construct a religious orientation index: percent Catholic and percent Southern Baptist Convention. An index score was created by converting the variables to z-scores, adding the scores together, and then dividing the total by the number of items used to compose the index.

These indicators of religious orientation are based on two premises; 1) the Catholic Church maintains unqualified opposition to abortion, and 2) as a group, abortion opponents maintain a fundamentalist religious orientation to the world. Use of this index assumes that states with a stronger fundamentalist religious orientation will have lower abortion rates and provider rates.

The two indicators of family structure are the percent of families with children less than 18 years of age, and the divorce rate per 1,000 population. The first indicator is a measure of family presence in the population and is used to indicate a pro-family value.

According to Luker (1984), Liu (1977), and Markson (1982), the abortion conflict reflects a threat to the traditional view of the family. For the purposes of this research, traditional family is indicated by the presence of married couples with their own children. Presence of the traditional image may be symbolic of a cultural climate which creates pressure to promote pro-family values and oppose abortion, and therefore may discourage availability of services.

The other indicator is used to portray family breakdown. One claim by abortion opponents is that abortion is symbolic of the breakup of the nuclear family. Thus, the divorce rate is used to measure marital breakup. It is expected that family breakdown is positively associated with availability of abortion services.

Reproductive Rights: The Feminist Interpretation of Abortion

The indicators of the feminist interpretation of abortion are measures of gender equality with respect to the economic status of women. The status of women is defined as the position of women as a group relative to the position of men as a group (Hommes 1978). Four economic equality indicators are used: 1) percent of females 16 years and older who are in the civilian labor force relative to the percent of males in the civilian labor force, 16 years and older, 2) percent of females labor force members who are employed relative to the percent of male labor force members who are employed, 3) the median income of female full-time workers relative to the median income of male full-time workers, and 4) percent of female headed households with incomes above the poverty level relative to the percent of male headed households above the poverty level. These four variables are

used to construct a status of women index. The procedure used to create the status of women index was the same as the one used to construct the religious orientation index.

These items were based on the construction of the economic dimension of the Status of Women Index by Yllo (1980) and its reconstruction by Sugarman and Straus (1988). It is hypothesized that more abortion services will be available in those states in which women have achieved a relatively high degree of economic equality.

Abortion Restrictions

The indicator of abortion restrictions is the degree of restrictiveness of abortion laws passed by states between 1973 and 1975 as calculated by Johnson and Bond (1980). The index includes 17 types of restrictions (e.g. parental consent) and adjusts for the severity of each state's laws. For each law, a state was given a score ranging from 0-3. According to Johnson and Bond (1980, pp. 114-115), a state scored 2 for enacting the law, a 1 if there were less restrictive exceptions to the law, or a 3 if there were a restrictive provision to the law. The total score ranged from 0 (no restrictions) to 27 (see Appendix A for the list of state laws). The mean score is 9.7, with a great deal of variation across states (s.d.=9.47). The higher the score, the greater the effort by the state to regulate abortions (Johnson & Bond 1980). Seventeen states had a score of 0, and 2 states had a high score of 27; Illinois and Pennsylvania. Table 4.6 shows the state rankings on the variable.

This measure of abortion restriction is used in both the 1976 and 1982 regression analyses. The difficulties with such regulations is

TABLE 4.6 State Ranks for Total Restrictiveness Index 1973-1975.

STATE	TOTAL RESTRICTIVENESS INDEX
PENNSYLVANIA	27.00
ILLINOIS	27.00
NORTH DAKOTA	26.00
MONTANA	25.00
MISSOURI	25.00
INDIANA	23.00
NEBRASKA	23.00
NEVADA	21.00
VIRGINIA	21.00
IDAHO	20.00
SOUTH CAROLINA	20.00
MASSACHUSETTS	18.00
UTAH	18.00
LOUISIANA	18.00
GEORGIA	17.00
SOUTH DAKOTA	16.00
NORTH CAROLINA	15.00
KENTUCKY	15.00
TENNESSEE	14.00
OHIO	13.00
MINNESOTA	13.00
MAINE	9.00
WYOMING	8.00
NEW JERSEY	8.00
MARYLAND	8.00
MICHIGAN	8.00
NEW YORK	6.00
ARIZONA	6.00
WISCONSIN	6.00
RHODE ISLAND	6.00
CALIFORNIA	3.00
HAWAII	2.00
VERMONT	1.00
ALASKA	0.00
COLORADO	0.00
WASHINGTON	0.00
OREGON	0.00
NEW MEXICO	0.00
NEW HAMPSHIRE	0.00
FLORIDA	0.00
CONNECTICUT	0.00
ALABAMA	0.00
DELAWARE	0.00
KANSAS	0.00
IOWA	0.00
TEXAS	0.00
OKLAHOMA	0.00
ARKANSAS	0.00
WEST VIRGINIA	0.00
MISSISSIPPI	0.00

that they are in a constant state of flux and have taken effect at different times, and therefore, the effectiveness of the law may change over time. It may be best to view the restrictiveness index as an indicator of an underlying restrictiveness climate that could influence the distribution of abortions and providers throughout the period since 1973.

Johnson and Bond (1980) found that their measure was not strongly related to the 1976 abortion rate. They suggested that a reason forthe weak relationship is that laws have not been in effect long enough to have a significant impact. Use of their measure in this studyprovides an opportunity to replicate their findings, and to determine whether there is a lag time between enactment and effect of abortion regulations.

The Role of the Health Care System

The fifth component is comprised of two aspects of the health care system: the characteristics associated with the adequate provision of health care services and the demand for health care by populations at risk of needing abortion. These two aspects represent features which frame abortion as a health care service. Health care institutions were given responsibility for the provision of abortion services, so it may be argued that abortion can be viewed as another service provided by the health care system. The two indicators used to measure the characteristics associated with adequate delivery of health care services are percent of population residing in metropolitan areas, and the number of medical practitioners per 100,000 population. Both indicators are important for the existence

of a network of good health care facilities. According to Lowenduski and Outshoorn (1986), such a network is crucial for the availability of abortion services. Furthermore, Legge (1985) stressed that availability of abortion services shared the same problems as other health services. If availability of abortion services is similar to other health related services, then availability of services will be associated with higher patient volume and more medical practitioners.

The four indicators of the demand for abortion health care, are 1) the size of the black population as a percentage of the total population, 2) the median school years completed, 3) the percentage of unmarried women in the population, and 4) the proportion of females aged 15-44 in the population. The indicators chosen are based on a demographic profile of the women obtaining abortions estimated by the Alan Guttmacher Institute. It is important to remember that the unit of analysis in this research is the state. Hence, speculations about the relationship between abortion policy and individual abortion behavior must be cautious. Racial composition is included based on the consistent finding that the abortion rate is higher for nonwhite women than for white women. It has been suggested that the difference between the two rates is due to higher incidence of unplanned pregnancies among nonwhite women (Henshaw Forrest & Blaine 1984). Therefore, it is predicted that a state with a large black population has a greater demand for abortion services. The use of education in this context is not as clear-cut as the other indicators, since all women with unwanted pregnancies may be in need of the service regardless of education. Nevertheless, the Alan Guttmacher Institute

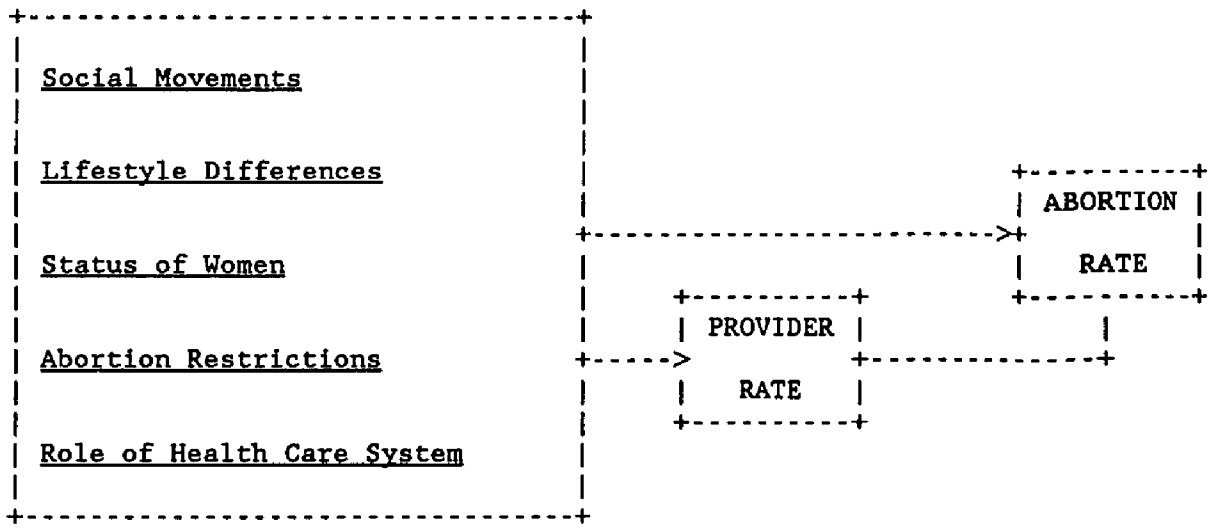
has suggested that less educated women may be in need of services since they have less access to information and private physician services (Henshaw and O'Reilley 1983). Percent unmarried women is included since reports from the Alan Guttmacher Institute have consistently shown that the abortion rate is higher for unmarried women that for married women. Since abortion services are utilized by women of childbearing ages, it is believed that a population with a higher proportion of women aged 15-44 will have a greater demand for services. If it is assumed that abortion services are similar to other health care services, then characteristics of the population demanding the service, such as racial composition, education, marital status or proportion of females age 15-44 in the population, may explain state-to-state differences in the distribution of abortion services.

IMPLEMENTATION MODEL OF ABORTION SERVICES

Figure 4.1 diagrams the two models to be tested in Chapter 6. Both models specify the same social, political and demographic variables as predictor variables. The first model investigates the direct effects of the predictor variables on the provider rate; the second tests the effects of the predictor variables and the provider rate on the abortion rate.

This model of implementation differs from typical implementation models. Usually the word 'implementation' is synonymous with a

Figure 4.1 Implementation Model of Abortion Services.



program and its execution. Within that framework, implementation analysis tends to look at what the program is, who is administratively responsible for carrying out the program, and then proceeds to evaluate the appropriateness of the type of administrating organization with the intended goal and the actual goal. In the model presented in this research, implementation is placed into a broader policy making environment and factors such as the general culture surrounding the abortion issue are suggested as important to state implementation of the Supreme Court decision.

The goal of this model is to explain state variation in abortion services - the abortion rate and provider rate. The variables chosen to account for the variation among states emphasize that policy implementation does not occur in a social vacuum. This model provides a useful framework for identifying crucial variables and looking at the broader social environment in which implementation takes place.

Chapter 5

RECENT TRENDS IN ABORTION SERVICES

Since the 1973 Supreme Court ruling on abortion, the proportion of women who legitimately terminate their pregnancy has risen steadily. Legalization, public funding, and social legitimacy have all contributed to the continued increase in abortions. In this chapter the recent trends in the abortion rate (1973-1982) and the provider rate (1976-1982) by year are examined. In essence, the descriptive information presented in this chapter is a detailed look at the dependent variables used in Chapter 6. The implementation model tested in Chapter 6 examines the 1976 and 1982 abortion rate and provider rate. This chapter discusses the trends in these rates between the two years. The data are the mean abortion rates and provider rates by year. In the first portion of this chapter, the overall trends in the abortion rate and provider rate are discussed. In the second portion, I look at the states which showed exceptionally large changes between the two years.

CHANGES IN ABORTION AND PROVIDER RATES

Abortion Rate

Table 5.1 shows the descriptive statistics for the abortion rates by year. Figure 5.1 graphically demonstrates the continued increase

TABLE 5.1 Descriptive Statistics for Abortion and Provider Rates by Year.

	MEAN	STD DEV	MINIMUM	MAXIMUM
ABORTION RATE				
1973	12.68	7.36	1.60	32.00
1974	15.45	7.17	3.10	32.80
1975	17.86	7.65	3.70	34.20
1976	19.42	8.09	8.10	38.80
1977	21.92	8.21	10.20	42.30
1978	23.69	8.31	9.20	45.40
1979	23.87	8.10	11.40	44.10
1980	24.37	8.22	12.00	43.60
1981	24.41	8.74	10.90	44.90
1982	23.93	8.55	11.20	44.50
PROVIDER RATE				
1976	5.29	3.63	0.71	15.54
1977	5.94	4.30	0.71	22.28
1978	6.48	5.27	0.71	26.74
1979	6.26	4.64	1.42	24.87
1980	5.43	3.82	1.33	20.83
1981	5.84	4.18	1.30	20.83
1982	5.95	4.37	1.30	22.13

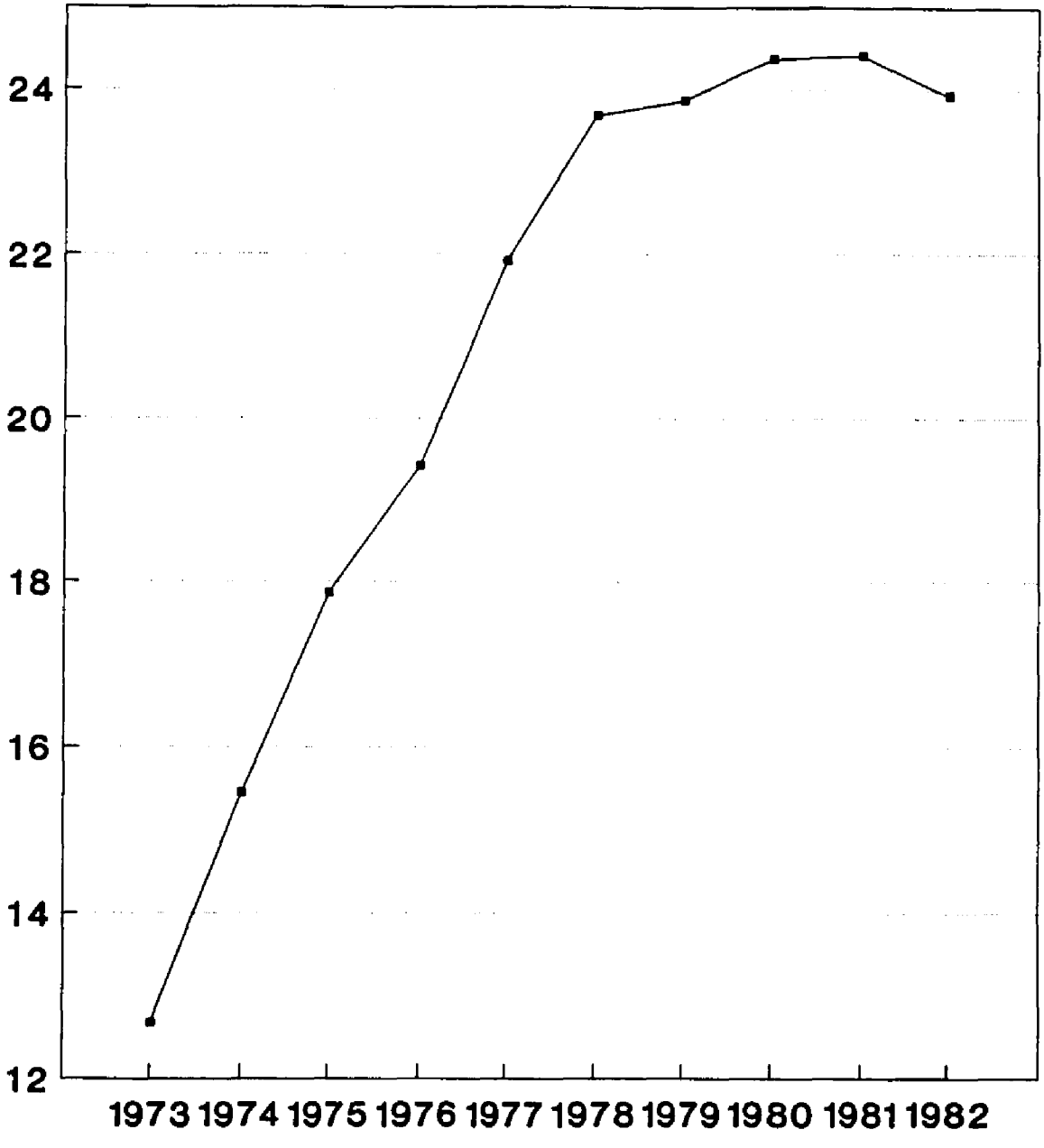


FIGURE 5.1 MEAN ABORTION RATE BY YEAR
1973 - 1982

in abortion rates over time. This finding is consistent with the annual findings of the Alan Guttmacher Institute's survey of health institutions and private physicians providing abortion services in the United States. The total number of women obtaining abortions increased steadily after the 1973 Supreme Court decision. After rising each year from 1973 to 1979, the abortion rate plateaued and showed little change after 1980, and 1982 was the first year in which the abortion rate showed any decline, as slight as it was.

In conjunction with the increased abortion rate, states have gained more leeway in regulating when and under what circumstances a woman may decide to terminate her pregnancy. As mentioned in Chapter 3, the passage of the Hyde Amendment shifted the momentum of the abortion debate towards a direction that favored and tolerated restrictions on legal abortion. States regulate many aspects of the abortion decision: they may require doctors to perform abortions, under certain circumstances they may limit a minor's access to abortion services, they may require women to give informed consent which may include information required by the state, they may protect facilities and individuals who object to participating in abortions, limit insurance coverage for elective abortions, and states may limit or prohibit the use of public funds for abortions (NARAL 1988). These restrictions can result in delays by women in obtaining abortions. Abortions obtained at later gestational stages add to the risk of complications that have been associated with adverse maternal health. Also, it is often difficult to find a facility that will perform the abortion procedure after the twelfth week of pregnancy. Despite this

wide variety among states in the way access to abortion is regulated, women continue to obtain abortions.

The rise in legal abortions also coincides with major gains for women as a whole. Such changes include expansion of higher education and technical training for women, and an expanding economic market for women's labor (Petchesky 1984). These changes have set a stage of improved economic and social conditions for women, or, at least created the expectation of improving conditions.

Provider Rates

In large part, the rise in the abortion rate from 1973 to 1975 is attributable to the rapid diffusion of abortion providers in the United States (Henshaw, Forrest & Blaine 1984). Table 5.1 shows the descriptive statistics of the provider rates from 1976 to 1982. Figure 5.2 illustrates the trend in the provider rate between these years. Data on the number of providers in each state are not available prior to 1976. The graph shows that the provider rate continued to increase from 1976 to 1978, decreased dramatically in 1980, and after 1980 the rate started to climb again. In 1982, the mean provider rate was slightly above the 1977 rate. Surprisingly, the increase in provider rates occurs at a time when abortion regulations are directed towards services, rather that limiting the method of payment or placing restrictions on the procedure itself.

The timing of the sharp decrease in the provider rate (1978-1980) coincides with two relevant occurrences. One change is the Congressional response to the Supreme Court decision. Between 1978 and 1979, Congress introduced, hotly debated, and eventually passed

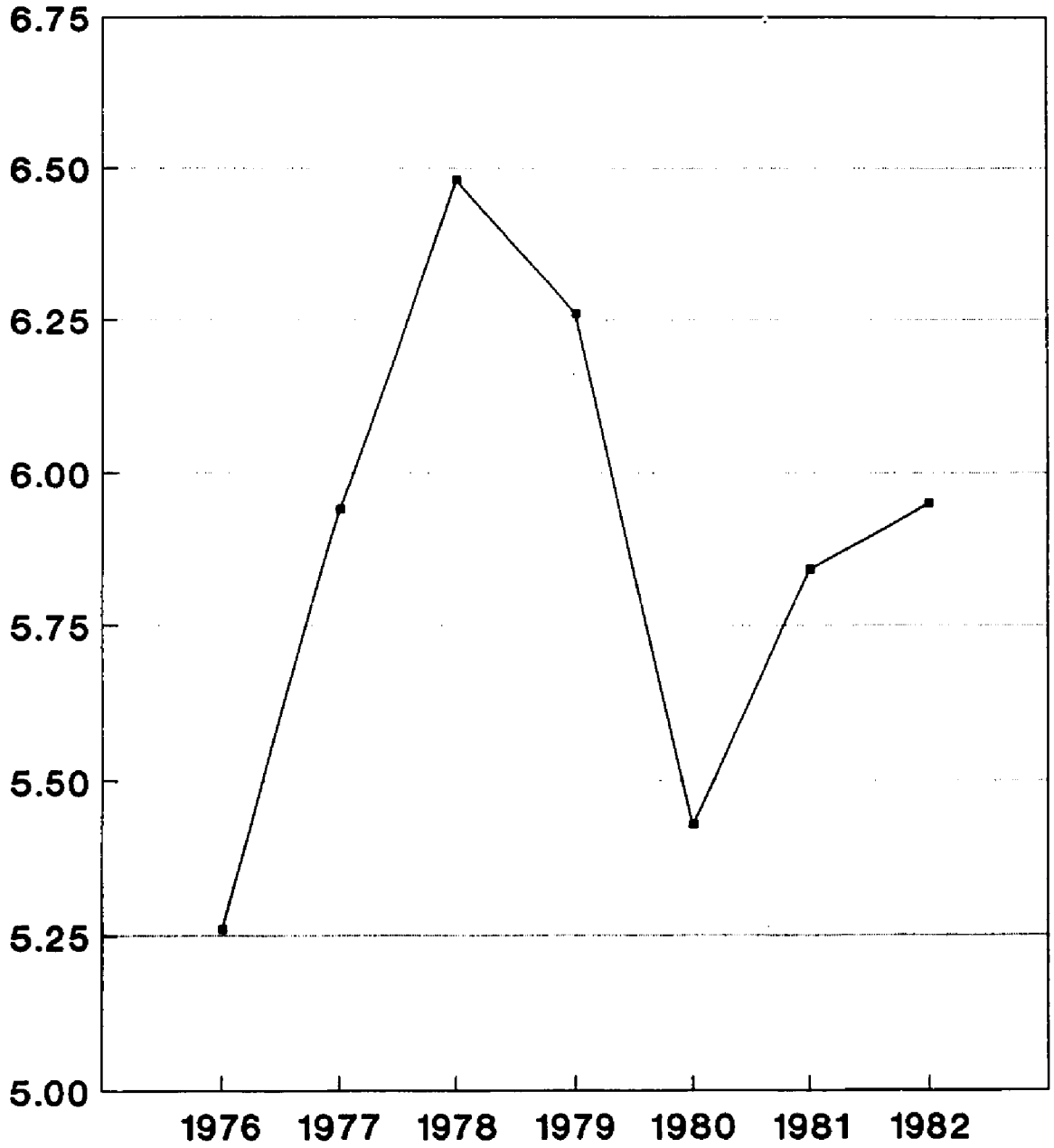


FIGURE 5.2 MEAN PROVIDER RATE BY YEAR
1976 - 1982

the Hyde Amendment. Although the Hyde Amendment had little to do with services per se, the amendment had the potential to affect abortion facilities by decreasing their caseload. Afterall, it was expected that women depending on public funds for abortion would be unable to pay, and therefore not obtain the needed services.

The second occurrence is the shift in type of services performing abortions. Lindheim (1979) reported that after 1976, the distribution of hospital facilities performing abortion showed little change, while the network of non-hospital facilities increased. Non-hospital facilities tend to have larger abortion caseloads that hospitals. In urban areas, a small number of providers may be able to reach a large number of women in need of services. In a more rural state, however, more providers would be needed to service a more dispersed population.

In part, the decline in the provider rates between 1978 and 1980 may be due to the simultaneous occurrence of these two events. That is, the decrease in the number of hospital abortion services, which tends to have small abortion caseloads and depend on public funds, may have been occurring at a time when larger facilities began handling a more sizeable caseload. If so, then the number of doors closing would be larger than the number of doors opening, even though one large door can influence a state's abortion rate. Although the provider rate has increased since 1980, along with the abortion rate, the fact remains that the geographic distribution of abortion providers continues to be markedly uneven. Availability of abortion providers provides women with important "material circumstances" that can broaden the range of

possibilities and provide women with more control over their lives (Petchesky 1984, p. 161).

ANALYSIS OF CHANGE - STATE EXAMPLES

A variable based on the difference between the earlier rate and the later rate was created for both the abortion rate (1976 and 1982) and provider rate (1976 and 1982). The states were ranked in descending order according to the values on these two variables. Louisiana and Maryland showed the largest increase in abortion rates between the two years, and Hawaii and Maine showed the largest increase in number of abortion providers per 100,000 women of reproductive age. The state of Washington showed a decrease in provider rates between 1976 and 1982. A graphic representation of these state trends, and a brief profile of the states which showed substantial change between the years are discussed in this portion of the chapter.

Abortion Rates - Louisiana and Maryland

Abortion rates for Louisiana and Maryland between the years 1973 and 1982 are illustrated in Figure 5.3, along with the overall trend in abortion rates. Both states show a similar pattern; an increase from 1973 to 1977, a sudden drop in 1978, and a gradual climb to pre-1978 values. By 1981 both states surpassed their 1977 rate.

The change in Louisiana's abortion rate was not due to any substantial increase in availability of abortion providers. In both years, Louisiana's provider rate was much lower than the average of

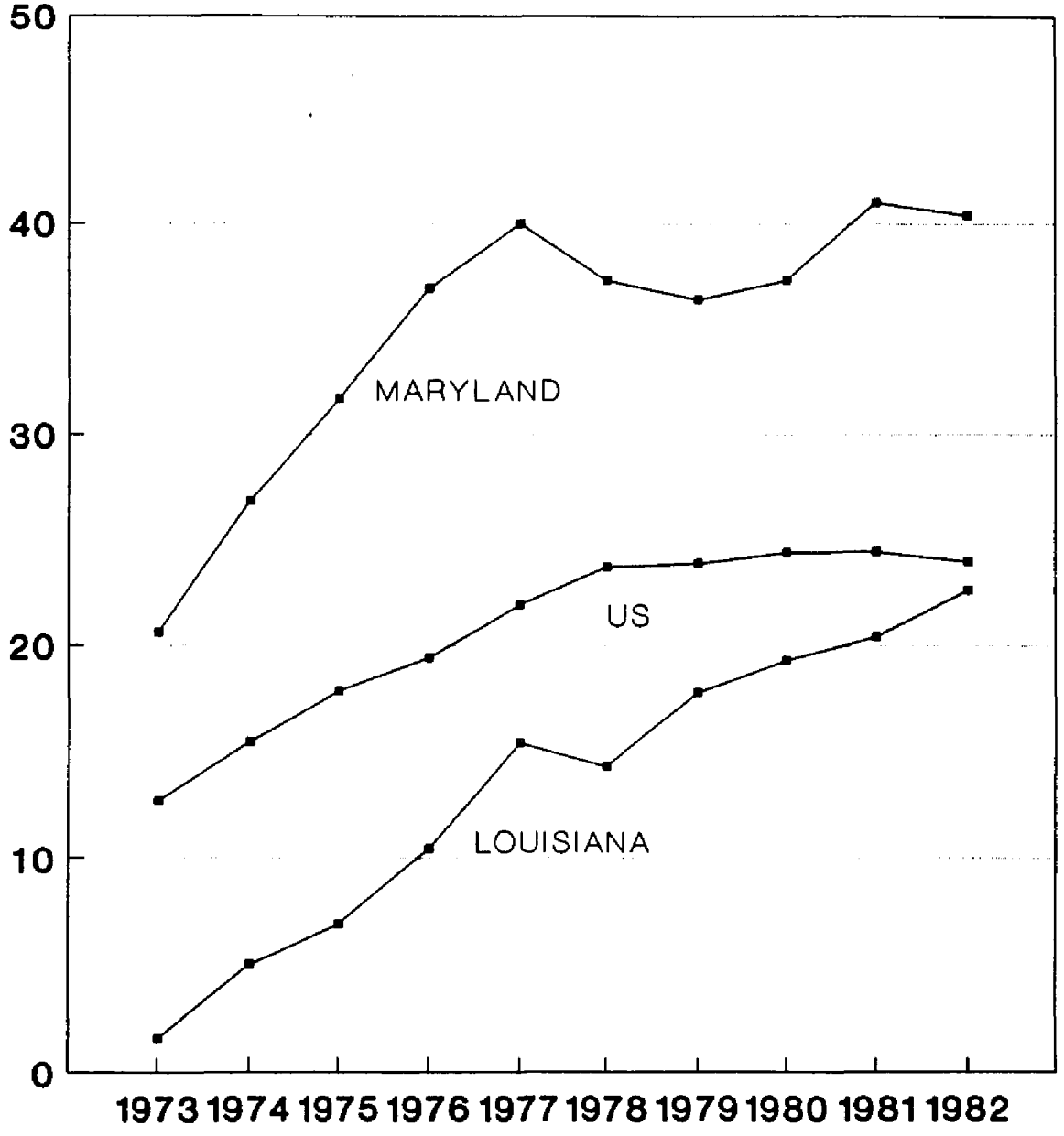


FIGURE 5.3 ABORTION RATES FOR MARYLAND, LOUISIANA, AND ALL 50 STATES 1973 - 1982

all states. That rate changed from 1.6 to 1.8. Such a slight change is difficult to interpret. The Alan Guttmacher Institute reported that Louisiana was one of four states in which abortions occurring in clinics established since 1978 accounted for a sizeable increase in the state's abortion rate (Henshaw, Forrest, Sullivan & Tietze 1982). The slight increase in the provider rate could represent the addition of a single abortion facility in Louisiana. If so, then the increase in the state's abortion rate suggests that the addition of new facilities, especially a clinic, can influence a state's abortion rate.

In Louisiana, public funds for abortion are unavailable except to save the life of the woman. According to a report by NARAL (1988), Louisiana is one of five states which intend to regulate or outlaw abortion if this ever became a legal possibility. On the Restrictiveness Index, Louisiana has a score of 18 out of a possible 27. Given the unsupportive atmosphere in the state, women in need of services continue to obtain abortions.

In contrast, Maryland is a state with one of the highest abortion rates between 1973 and 1982. Figure 5.3 shows the abortion rate in Maryland consistently remained above the overall abortion rates during the 9 year span. Although the abortion rate increased over time, the number of providers available changed slightly from fewer than 4 providers to a total of 5 providers per 100,000 women of reproductive age. Perhaps this change in the state's abortion rate is partially attributable to the addition of a non-hospital type facility. Maryland is one of eight states that voluntarily pays for abortion for

women who depend on the government for health care services. On the Restrictiveness Index, Maryland has a score of 8.

Provider Rates - Hawaii, Maine and Washington

Hawaii, Maine, and Washington all ranked relatively high for provider rate between 1976 and 1982. Figure 5.4 shows the trends for these three states between 1976 and 1982, as well as the average provider rate trend. The overall trend was lower and somewhat more stable over time than the fluctuating provider rates for Hawaii, Maine, and Washington. Although Washington showed a decline in the number of providers available, the trend in that state's provider rates remains higher than the overall trend. The trend in provider rates is different for each state. The one common feature is the 1980 decline in the provider rate for all three states, and for the overall provider rate value, as well.

Hawaii consistently has had higher provider rate values than the other 49 states. In Chapter 4, I suggested that the geographic location of the state may create pressure within the state to provide the needed service. Historically, Hawaii has been liberal in terms of issues surrounding abortion. It repealed its anti-abortion statute in the 1970's, making Hawaii one of the seventeen states which had already relaxed restrictions in abortion before the 1973 Supreme Court decision. Hawaii is also one of eight states to voluntarily fund abortion services for poor women. Hawaii has a low score of 2 on the Restrictiveness Index.

In 1976, Maine had fewer than eight providers per 100,000 women of reproductive age, and by 1982 it had slightly more than 15 providers

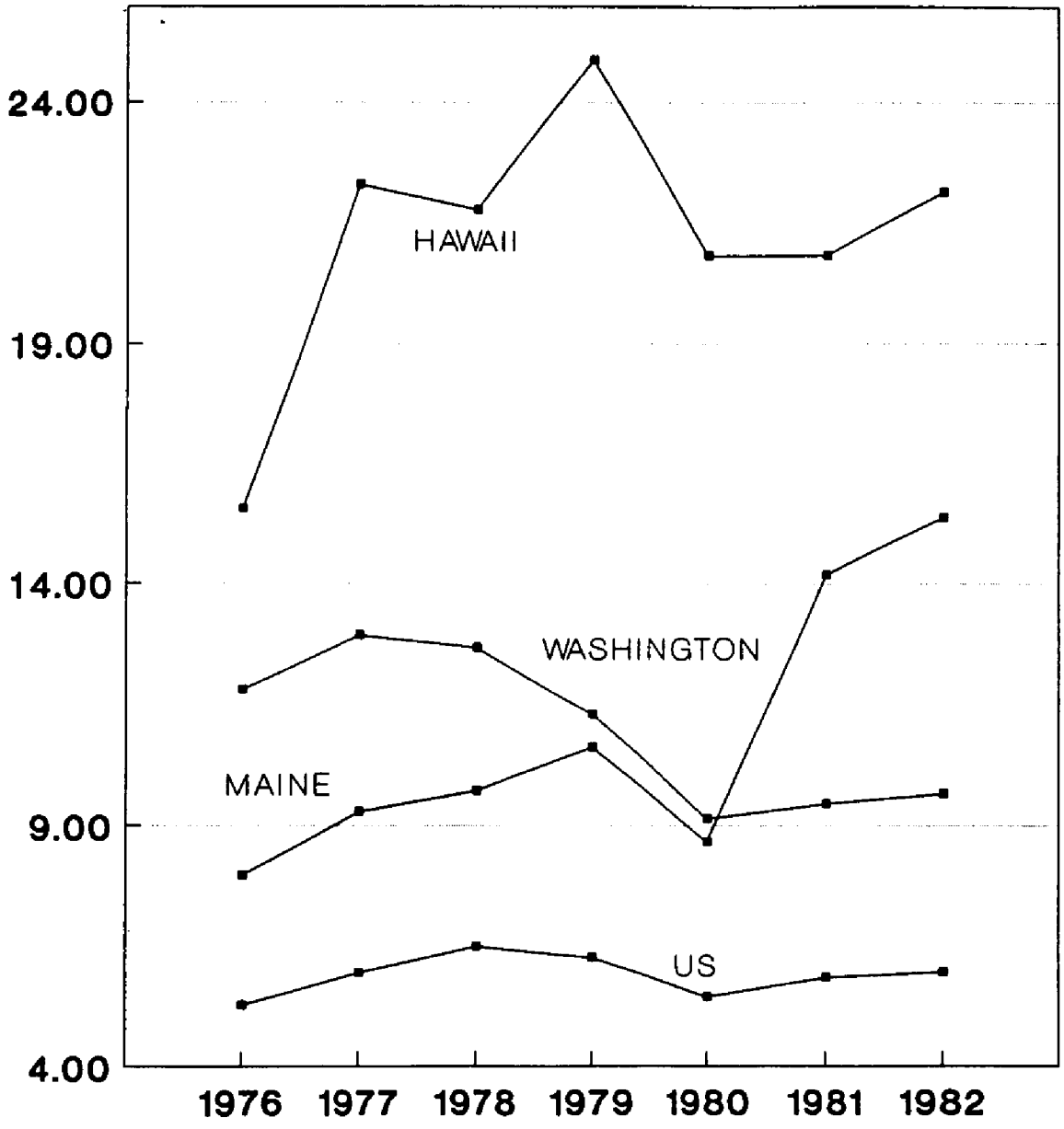


FIGURE 5.4 PROVIDER RATES FOR MAINE, HAWAII, WASHINGTON, AND ALL 50 STATES 1976 - 1982

available. In terms of the abortion rate, the state's rate has increased from 12 in 1976 to 21 in 1982. However, Maine's abortion rate has consistently been below the average abortion rate for the country; the state ranked 41 in 1976 and 30 in 1982. On the Restrictiveness Index, Maine shows a score of 9. Public funding for abortion is available in order to preserve the life of the woman. For a large rural state, Maine's increase in provider rate is impressive. The addition of new providers in Maine has enabled more women to terminate unwanted pregnancies by abortion or to do so without traveling to other states.

It was surprising to see that 6 states showed a loss of at least one provider per 100,000 women aged 15-44, and Washington was the only state to lose at least two providers. Besides Washington, the other states that showed a decrease in provider rates were North Carolina, Illinois, Nebraska, Pennsylvania, and New Mexico. North Carolina, Nebraska, and New Mexico all have large rural populations. It is difficult to pass judgment about the loss of provider services without knowing what type of services were discontinued. The closing of a large facility would have more of an impact than a facility which performs a few abortions every year. The loss of providers places an additional burden on women in need of services. The need to travel elsewhere for services increases the cost because of traveling expenses, and increases the risk that the abortion will be delayed.

On the positive side, Washington voluntarily funds abortion for women who depend on public funds for their health care service. Also,

Washington is one of 17 states with a score of 0 on the Restrictiveness Index.

SUMMARY

Since 1978 the percentage growth in the abortion rate has become smaller each year. And, 1982 was the first year since 1973 in which the abortion rate stopped climbing. The stable abortion rate does not imply that abortion providers are available to all women who need services. There is ample evidence that many women are unable to obtain abortion services.

Three of the five states showing large changes in abortion rate or provider rates continue to subsidize abortions for indigent women, while the other two states, Maine and Louisiana, provide funding only to preserve the life of the mother. The changes in Maine and Louisiana are interesting. Both states contain a sizeable rural and poor population. Low income women and women living in rural areas are most often in need of services and unable to obtain them. Distance and cost are two factors that present obstacles for many women. Between 1976 and 1982 both states showed an increase in abortion rates and provider rates. The abortion rate, especially, showed a sizeable increase. Upon examination of their provider rates, the change in Louisiana's rate is negligible and unimpressive compared to the change in Maine's provider rate. The changes in Maine's and Louisiana's abortion rate suggest that the availability of abortion providers has

an important effect on the utilization rate. The changes in Louisiana's provider rate also suggests that the opening of a single facility can influence a state's abortion rate. Large non-hospital facilities (performing 400 or more abortions per year) represent more available services because they are more visible, and frequently they are the location of abortion services for many women of surrounding areas. In addition, large facilities are less likely to impose restrictions on services (Henshaw et al. 1984).

In the case of Washington, it is difficult to assess the overall effect of the decrease in the state's provider rate without knowing what type of facility stopped providing abortion services. The different types of abortion providers and factors related to their availability are discussed in Chapter 7.

This chapter focused on abortion rates and provider rates and provided some suggestions about the relationship between the two rates. Other social and political factors, such as the general culture surrounding the abortion issues, may influence the availability of providers and the utilization rate. The implementation model developed in this research tests the contribution of these factors to the availability of abortion services. In the next chapter this model is tested.

Chapter 6

ABORTION SERVICES AND THE FIVE COMPONENTS OF ABORTION

The present chapter reports findings from regression analyses of the relationship between abortion services and five types of factors reflecting various aspects of the current abortion issue. To reiterate, the five factors hypothesized as influencing the availability of abortion providers and the abortion rate are: the presence of anti- and pro-abortion social movements, lifestyle differences between abortion advocates and opponents, the feminist struggle for reproductive rights for women, the attempts to control abortions through restrictions, and the role of the health care system.

This chapter is divided into three sections. The first section summarizes the preliminary findings. Initial diagnostics were run on all the variables in the model to check for multicollinearity among the independent variables. If two variables were highly collinear, then the one variable showing the highest relationship with the dependent variables was kept in the model. Next, the remaining effects of the variables are estimated in a preliminary regression model. Variables with a regression coefficient larger than its standard error are used in the final model. The findings from the preliminary analyses are discussed and presented in this first section. The second section reports the final estimates of the four models: 1976 provider rate, 1976 abortion rate, 1982 provider rate,

and 1982 abortion rate. The major difference between the 1976 and 1982 models is that a measure of social movement activity has been included in the 1982 models. In the last section, consideration of another statistical model to analyze the data is discussed. Specifically, the advantages and disadvantages of using a pooled cross section and time series model with this data set are explored.

PRELIMINARY FINDINGS

Tables 6.1 and 6.2 show the intercorrelations for all the independent variables used in the 1976 and 1982 models, respectively. Table 6.3 presents the regression results for the four models. The provider rate was included in the model estimating the abortion rate, which increased the explained variance in both years. The bottom row of Table 6.3 shows the extent to which the predictor variables account for the variation in each of the four dependent variables. In 1976, they accounted for 54% of the variation in the provider rate, and explained 68% of the variation in the abortion rate. By 1982, the predictors explained only 43% of the variation in the provider rate, but explained 84% for the abortion rate.

'Significant' findings refer to estimates of the variables with an unstandardized regression coefficient equal to or larger than its standard error. Unstandardized coefficient values equal to or larger than its standard error corresponds to a probability level of .10, and unstandardized coefficient values greater than twice the standard

TABLE 6.1 Intercorrelations of Measures of Abortion Issue, Provider Rate, and Abortion Rate, 1976.

	2	3	4	5	6	7	8
1. Religious Orientation	-.126	-.244	-.025	-.046	.145	.187	.420
2. Families		.039	.036	-.043	-.137	-.167	-.110
3. Divorce			-.003	-.162	-.267	-.003	-.068
4. Status of Women Index				-.044	.232	.095	-.119
5. Restrictiveness Index					-.156	-.015	.076
6. Physicians						.608	-.141
7. Metropolitan							.177
8. Black							
9. Unmarried							
10. Education							
11. Females							
12 Abortion Rate							
13. Provider Rate							

	9	10	11	12	13	MEAN	STD DEV
1. Religious Orientation	.591	-.459	-.115	.022	-.159	0.00	0.47
2. Families	-.260	.349	.436	-.142	.225	54.18	3.13
3. Divorce	-.327	.152	.285	.036	.408	5.49	2.31
4. Status of Women Index	.130	.147	.167	.332	.354	-0.06	0.58
5. Restrictiveness Index	-.007	-.086	-.063	-.142	-.288	9.72	9.47
6. Physicians	.569	.374	.237	.735	.344	152.83	40.10
7. Metropolitan	.513	.166	.346	.664	.019	58.31	25.26
8. Black	.288	-.641	.109	.062	-.286	8.95	9.28
9. Unmarried		-.187	.043	.444	.036	39.84	1.95
10. Education			.341	.312	.470	12.47	0.18
11. Females				.406	.309	0.22	0.10
12 Abortion Rate					.441	19.42	8.09
13. Provider Rate						5.29	3.63

TABLE 6.2 Intercorrelations of Measures of Abortion Issue, Provider Rate, and Abortion Rate, 1982.

	2	3	4	5	6	7	8	9
1. Religious Orientation	-.266	-.262	-.423	-.012	.120	.205	.232	.199
2. Families		.073	.035	.042	-.149	-.224	-.294	-.341
3. Divorce			.101	-.102	-.252	-.142	-.377	-.075
4. Status of Women Index				-.024	-.005	-.201	.191	.082
5. Restrictiveness Index					.138	.242	-.098	-.035
6. Anti-Abortion Movement						.450	.146	.244
7. Pro-Abortion Movement							.073	.266
8. Physicians								.669
9. Metropolitan								
10. Black								
11. Unmarried								
12. Education								
13. Females								
14 Abortion Rate								
15. Provider Rate								

	10	11	12	13	14	15	MEAN	STD DEV
1. Religious Orientation	.415	.527	-.519	-.109	.156	-.247	0.01	0.46
2. Families	-.148	-.432	.281	.545	-.303	.176	52.42	3.24
3. Divorce	-.097	-.399	.194	.221	.131	.326	5.66	2.25
4. Status of Women Index	-.469	-.113	.522	.228	.179	.450	-0.05	0.58
5. Restrictiveness Index	.071	-.006	-.185	-.134	-.215	-.278	9.72	9.47
6. Anti-Abortion Movement	.081	.204	-.082	-.087	.206	.023	0.51	0.51
7. Pro-Abortion Movement	.134	.148	-.043	-.206	.104	-.168	0.18	0.39
8. Physicians	-.029	.740	.264	.231	.716	.207	171.60	42.75
9. Metropolitan	.188	.617	.108	.209	.719	-.018	61.37	22.85
10. Black		.453	-.690	.102	.157	-.301	9.14	9.22
11. Unmarried			-.251	.134	.619	-.007	43.38	3.40
12. Education				.290	.255	.493	12.48	0.19
13. Females					.401	.431	0.23	0.01
14 Abortion Rate						.468	23.93	8.55
15. Provider Rate							5.95	4.37

TABLE 6.3 Preliminary Regression Estimates of Measures of Abortion Issue on Provider Rate and Abortion Rate, 1976 & 1982.

	1976						1982					
	Provider Rate			Abortion Rate			Provider Rate			Abortion Rate		
	b	s.e.	Beta	b	s.e.	Beta	b	s.e.	Beta	b	s.e.	Beta
Anti-Abortion Movement							1.78*	1.09	0.21	1.89*	1.16	0.11
Pro-Abortion Movement							0.45	1.60	0.04	-0.87	1.64	-0.04
Religious Orientation	-0.39	1.07	-0.05	-2.01*	2.00	-0.12	-0.60	1.44	-0.06	1.01	1.48	0.06
Families	0.24*	0.15	0.20	-0.47*	0.30	-0.18	0.15	0.29	0.11	-0.57*	0.29	-0.22
Divorce Rate	0.91**	0.19	0.58	-0.15	0.45	-0.04	0.91**	0.31	0.47	0.81**	0.36	0.21
Status of Women Index	1.34**	0.63	0.22	1.52*	1.24	0.11	1.83*	1.10	0.24	-0.99	1.17	-0.07
Restrictiveness Index	-0.03	0.04	-0.09	-0.01	0.07	-0.01	-0.09*	0.06	-0.20	-0.02	0.06	-0.02
Physician Rate	0.05**	0.02	0.56	0.07**	0.03	0.36	0.03*	0.03	0.30	0.07**	0.03	0.35
Metropolitan	-0.06**	0.02	-0.43	0.10*	0.04	0.32	-0.09*	0.03	-0.48	0.11**	0.04	0.28
Black	0.03	0.06	0.07	0.19*	0.11	0.22	-0.04	0.09	-0.08	0.24**	0.10	0.26
Unmarried	0.38*	0.31	0.20	0.02	0.58	0.00	0.48*	0.34	0.37	0.13	0.36	0.05
Education	4.38*	3.69	0.22	3.75*	6.98	0.08	3.68	5.38	0.16	9.96*	5.56	0.22
Females	-26.98	57.47	-0.07	112.74*	107.02	0.12	66.92	93.10	0.15	107.22*	96.37	0.12
1976 Provider Rate				0.65*	0.30	0.29						
1982 Provider Rate										0.62	0.17	0.32
Adjusted R^2		0.54			0.68			0.44			0.84	

* = Value greater than the standard error
** = Value greater than twice the standard error

error corresponds to a probability level of .05.

Previous research has suggested that region may be an important factor in explaining variations in abortion services (Frankel & Ward 1984; Henry 1982; and Henry & Harvey 1982). In order to determine the effect of region, another set of regression analyses was computed with three dummy variables for the four regions added to the equations. The results showed that the impact of region was stronger for the provider rates rather than the abortion rates. The adjusted R-squares for the 1976 provider rate increased from .54 to .61, and from .43 to .54 for the 1982 provider rate. In contrast, the adjusted R-squares decreased for the abortion rates with region estimated in the models. The adjusted R-square for the 1976 abortion rate changed from .68 to .66, and from .84 to .83 for the 1982 abortion rate. None of the parameters shifted directions in any of the equations. Regional variations appear to have the strongest effect on the 1982 provider rate and the least effect on the abortion rate of that same year. Overall, it was decided that the impact of region was not strong enough to warrant its inclusion in the models of abortion services.

Results

The strongest determinant of the 1976 provider rate was the divorce rate, followed in importance by the physician rate, percent metropolitan, status of women index, median education, percent families with own children, and percent unmarried females. Attempts to restrict abortions through regulations had virtually no effect on provider rates. Of the significant determinants of the provider rate,

all were in the predicted direction with the exception of percent metropolitan. This negative effect of urbanism does not support the hypothesis.

The 1976 provider rate was a strong determinant of the 1976 abortion rate. Independent variables which had strong effects on the provider rate did not necessarily have similar effects on the abortion rate of that same year. For instance, religion had a weak effect on the provider rate, but showed a strong effect on the abortion rate in the predicted direction. While the divorce rate showed a strong relationship with the provider rate, it had a weak effect on the abortion rate. The effect of family presence shifted directions from a positive relationship with the provider rate to a negative relationship with the abortion rate. While percent black and proportion of females aged 15-44 in the population had small effects on the provider rate in 1976, both showed a stronger relationship with the abortion rate. The percent metropolitan coefficient remained large, although it shifted directions; states with a large percentage of the population residing in metropolitan areas have fewer providers available, and have a higher abortion rate than less urban states.

Several variables that had strong effects on 1976 provider rates again had dominant effects on the 1982 provider rates, with the exception of median education and the measure of family presence. By 1982, the restrictiveness index had assumed a negative effect on the provider rate; states with fewer regulations tended to have more services. Activities of the anti-abortion movement had a significant effect on the provider rate, but not in the predicted direction. It

appears that there is more anti-abortion activity in states with a large number of services available . Pro-abortion movement had a weak effect on the provider rate.

Analysis of abortion rates showed that four of the seven variables related to the 1982 provider rate also had significant effects on the abortion rate: divorce rate, physician rate, percent metropolitan, and anti-abortion movement activity. The status of women index, the restrictiveness index, and the percent of unmarried females has negligible effects on the 1982 abortion rate. While family presence and several of the demand characteristics had no effect on the provider rate, they all had strong effects on the abortion rate.

Several variables that were significantly related to the 1976 abortion rate were related to the 1982 abortion rate, with the exception of religion and the status of women index. By 1982, the level of education and the divorce rate had assumed a positive effect on the abortion rate. Several variables measuring the role of the health care system on abortion services which had significant impact on 1976 abortion rates again had significant impact in 1982. The stability of the effects of provider rate on the measure of abortion utilization is indicated by comparison of the 1976 and 1982 results.

Several findings were not as expected. Possible reasons for these results are given below. First, the religious orientation index showed weak effects on both provider rates. A possible explanation for these weak effects may be found in the time periods used in this study. The year 1976 provides an unusual context for examining the abortion issue. It was a time when different forces were playing off

of one another. On the one hand, the momentum from the Supreme Court decision was still strong. Abortion had been legal for about three years and the demand for services was still high. The number of services was increasing, and free standing abortion clinics were beginning to replace traditional medical institutions in responding to the demand for care. On the other hand, the introduction of the Hyde Amendment in Congress initiated an atmosphere which tolerated restrictions against legal abortions, and the moral sentiment concerning fetal rights and the wrongness of abortion became part of the 1976 Republican presidential platform. In 1976 the momentum of abortion opponents was just beginning to build and coalesce in the public arena. Apparently, the influence of groups with fundamentalist values was not strong enough to affect the continued growth of abortion services. After 1976, growth in the number of services slowed down. By 1981, the issue of fetal personhood was less important, and social questions about family and teenage sexuality became dominant in the abortion debate (Petchesky 1984).

Second, it is surprising that percent black and proportion of females age 15-44 showed weak effects on the provider rates. One possible explanation is that the conceptualization of the black population and female population as indicators of the need for services is not refined enough to effect the provider rate. The tendency to analyze the black population as if all blacks were in need of services may be meaningless. The variable percent black was included based on the findings that the abortion rate for nonwhite women has been consistently higher than for white women. It therefore

was assumed that a state with a larger black population has a greater need for abortion services. Perhaps as the investigation of abortion services becomes more focused on the provision of services and types of providers, a more meaningful conceptualization of racial composition in relation to availability of abortion services would be better, such as percent black women in a state or proportion of black females of childbearing ages in the black population. This same line of reasoning is applicable to the use of the proportion females age 15-44 in the population. One suggestion would be to disaggregate the variable into smaller categories, such as proportion of females between the ages of 15 and 24. This age group is more reflective of the women of reproductive age who most frequently use abortion services.

Third, the status of women was not an important determinant of the 1982 utilization rate. The reduced effect can be understood within the context of the feminist position which claims that women alone have the right to control their fertility. The slogan 'a woman's right to choose' is based on the premise that women must decide whether or not to terminate a pregnancy. The struggle for reproductive freedom is not about the use of abortion services as much as it is about changing the conditions in which decisions are made about childbearing. In Chapter 3, the question was asked whether structured gender inequalities shape the conditions which influence the availability and use of abortion services. In terms of availability, the impact of women's status has shown to be influential as witnessed by its important effects on the provider rate.

Finally, in the preliminary analysis the restrictiveness index showed small negative effects on both the 1976 and 1982 abortion rates. Although negligible, the effects were in the predicted direction. It was expected that in states which had adopted more restrictive limitations on abortions that there would be a lower abortion rate. The findings do not support the predicted hypothesis. The results do agree with previous research findings which have shown that regulations against abortion have had a minor effect on the abortion rate (Gold & Cates 1980; Hansen 1980; Johnson & Bond 1980; and Petchesky 1984).

Summary

Some patterns do emerge from this preliminary estimation of the implementation model. First, physician rate and percent metropolitan consistently showed strong effects on the two separate measures of abortion services and for both years. In contrast to the hypothesis, the degree of urbanism is negatively related to availability of services, and positively associated with utilization of services. Characteristics associated with the existence of health care services play an important role in availability and use of abortion services. Second, racial composition and proportion of females aged 15-44 are unrelated to availability of services, but are strongly related to utilization of services. This finding is consistent with the literature; that is, those groups who use abortion services, and therefore, are most in need of services, show little relationship to the actual availability of services. This finding, however, does not hold up for the other two characteristics of the population at risk;

education and marital status. Third, restrictions on locations in which abortions may be performed and abortion procedures appear to have had only a minor impact on overall abortion rates.

The abortion provider rate showed a strong positive relationship with the abortion rate. What is surprising is that the provider rate was not the most powerful direct determinant of variation in the abortion rate. While availability of providers is a strong determinant of the 1976 and 1982 legal abortion rates, these rates are also, in part, a function of the divorce rate, proportion of unmarried women, median education, and status of women. While it is probable that increasing the availability of abortion providers has an important effect on the utilization rate, it is not the only factor.

Measures of lifestyle differences were too uneven to discern a pattern. We have to wait to see how they shape up in the final model before drawing any conclusions. So far, the preliminary findings show that availability and utilization of abortion services can not be explained by any one component of the abortion issue. Rather, abortion services seem to respond to the interrelationship of cultural climate, political pressure, and the role of the health care system. In the next section the results for the final models are discussed. By examining the effects of a more limited set of measures on the provider rates and abortion rates, it will be easier to detect patterns among the various components and explain the differences in availability and use of abortion services.

STATISTICAL MODELS OF ABORTION SERVICES

In this section the findings from the ordinary least squares (OLS) regression analysis of the separate models are discussed. This is a reduced model based on the results from the preliminary analysis. Variables which showed an unstandardized coefficient greater than or equal to its standard error were included in this final regression model. Table 6.4 shows the regression estimates of the variables in this reduced model.

Provider Rates

Together, the predictor variables account for 57% of the variation in the 1976 provider rate and 43% of the in the 1982 provider rate. Measures of the factors related to abortion availability seem to be better predictors of the 1976 rates rather than the 1982 provider rates.

Social Movement Activity. Social movement activity is included in the 1982 model of the abortion provider rate. Neither social movement measure is related to the provider rate as expected. It was predicted that strength of social movement activity would affect availability of abortion services. Specifically, it was expected that pro-abortion movement activity would be linked with increased availability, and anti-abortion movement activity would discourage the availability of services. Instead, the results show a positive relationship between anti-abortion activity and availability, and virtually no effect between pro-abortion activity and the availability of services. The

TABLE 6.4 Final Regression Estimates of Measures of Abortion Issue on Provider Rate and Abortion Rate, 1976 & 1982.

	1976						1982					
	Provider Rate			Abortion Rate			Provider Rate			Abortion Rate		
	b	s.e.	Beta	b	s.e.	Beta	b	s.e.	Beta	b	s.e.	Beta
Anti-Abortion Movement							1.78*	1.01	0.21	1.62*	1.03	0.10
Pro-Abortion Movement												
Religious Orientation				-2.27*	1.56	-0.13						
Families	0.21*	0.12	0.18	-0.38*	0.25	-0.15				-0.52**	0.25	-0.20
Divorce Rate	0.92**	0.17	0.59				1.03**	0.26	0.53	0.86**	0.32	0.23
Status of Women Index	1.29**	0.60	0.21	1.52*	1.15	0.11	2.53**	0.90	0.34			
Restrictiveness Index							-0.10**	0.05	-0.21			
Physician Rate	0.05**	0.01	0.58	0.08**	0.02	0.41	0.06**	0.02	0.55	0.09**	0.02	0.43
Metropolitan	-0.06**	0.02	-0.44	0.10**	0.04	0.32	-0.09**	0.03	-0.49	0.10**	0.03	0.27
Black				0.16**	0.08	0.18				0.27**	0.08	0.29
Unmarried	0.33*	0.26	0.18				0.12	0.24	0.10			
Education	3.57*	2.68	0.18							6.60*	4.45	0.15
Females				108.76*	95.16	0.12				93.09*	87.41	0.10
1976 Provider Rate				0.63**	0.21	0.28						
1982 Provider Rate										0.61**	0.15	0.31
Adjusted R^2	0.57			0.71			0.43			0.85		

* = Value greater than the Standard Error
** = Value greater than twice the Standard Error

findings indicate that in states where there is more anti-abortion activity there are more services available.

Several explanations can be given for these unexpected findings. First, there is the question of causal direction. Perhaps anti-abortion activity doesn't discourage abortion services per se, rather the movement is stronger, more active, and more visible in states where services are more readily available. Harassment of providers by anti-abortion activists assumes the existence of abortion services. Furthermore, the stated goal of the anti-abortion movement has been the restriction and elimination of legal abortions. Smelser (1962) noted that social changes which challenged or threatened traditional norms facilitate the mobilization of social movements. Eitzen (1985) further characterized social movement activity into more meaningful categories. Resistance movements are a type of social movement organized to reinforce the status quo by preventing change or wanting to reverse change that has already occurred. In the case of the abortion issue, the anti-abortion movement is an example of a resistance movement. The rise of the anti-abortion movement was in response to actual change, that is, the legalization of abortion. In contrast, the pro-abortion movement is a reform movement which seeks to change a specific part of society, or protect existing rights. Reform movements usually mobilize around a specific issue, such as abortion (Eitzen 1985). Based on this theoretical understanding of social movements, it follows that in states where there are more services available abortion movement activity will be strong: One movement to resist, and the other movement to protect existing rights.

This framework provides a theoretical understanding to the positive relationship found between anti-abortion activity and availability of abortion services. However, the question asked in this research is whether social movement activity affects the availability of abortion services. In terms of social movement activity, to test whether anti-abortion movement harassment has succeeded in stopping the provision of services, more observations of anti-abortion activity (as well as a more encompassing measure of social movement activity) and the provider rate over time would be required.

The lack of effect between pro-abortion movement activity and the provider rate may best be explained by the way it was measured. This indicator is based on a content analysis of articles reporting social movement activity referenced in NewsBank. Overall, there were twice as many articles about anti-abortion movement activity as pro-abortion movement activity. Furthermore, the articles about pro-abortion activity tended to be in response to articles about the activities of anti-abortion activists. Examination of Table 4.5 shows that states ranking high on anti-abortion activity also ranked high on the pro-abortion activity. Furthermore, the frequency of pro-abortion activity is roughly half that of the count for anti-abortion movement activity. Based on the findings, it seems that NewsBank may not have been the best resource for measuring pro-abortion activity. Also,it may be that anti-abortion activity is defined by journalists as more noteworthy and thus covered more extensively.

Lifestyle Differences. Two measures of family structure show

strong positive relationships to the 1976 provider rate: the percent of families with children and the divorce rate. The divorce rate maintains a strong effect on the 1982 provider rate. The other measures of lifestyle differences have weak effects on the 1982 provider rate. The positive effect of the divorce rate on the 1976 and 1982 provider rates is in the predicted direction, whereas the positive relationship between family presence and the 1976 provider rate is in the opposite direction. In terms of family presence, it was hypothesized that fewer services would be available in states where the moral climate supports traditional views of the family. Instead, the findings here show a positive effect of family presence on providers. One possible interpretation is that facilities which offered abortion services may have been housed in facilities that provided other health care services. Groups of women who used these services were therefore not limited to obtaining only abortion services. After legalization, hospitals were the primary institutions in which abortion could be obtained. Soon the number of hospitals offering abortion services decreased and the transition from services offered in hospitals to non-hospital facilities began around 1976 and 1977. Also, during this time the actions of abortion opponents were directed towards stopping abortion through regulating the procedure, such as consent requirements and funding limitations. Regulations intending to limit availability of services became increasingly more popular in the early 1980's. The positive relationship may not be indicative of pro-family sentiment in relation to abortion services. Rather, the relationship may reflect the high percentage of families

living near services offering other family health care needs.

The divorce rate was included in this model as indicating family breakdown, and reflects a value about the family on which abortion supporters and abortion opponents differ. In Chapter 3, it was stated that abortion opponents tend to promote a conventional view of marriage, and see motherhood as a natural role for women. Abortion supporters, on the other hand, are seen as more supportive and encouraging of nontraditional family forms. Motherhood is considered as a social role, and one of several social roles for women. Abortion supporters tend to have a strong belief in individual rights, and encourage the development of one's potential. From the standpoint of abortion supporters, availability of abortion services is an issue of individual rights, and control over reproduction is viewed as essential for women's self-determination. Earlier it was suggested that cultural conditions may give rise to pressures that would create and maintain abortion services. In such a climate, social constraints against abortion may be low. The findings support this position and suggest that a cultural climate more tolerant of changes in family structure will have more abortion services available.

Status of Women. The status of women index is a strong determinant of both the 1976 and 1982 provider rates. In states where women have achieved a relatively high degree of economic equality, there are more providers. The findings clearly support the hypothesis that the position of women in society influences the availability of abortion services. Comparison of the standardized beta coefficients in Table 6.4 reveals that the strength of the effect increased over time.

From the feminist interpretation of reproductive rights, legal abortion is seen as a response to changes in the social and economic conditions that structure women's lives. Women's entry into the labor force and actual employment requires a certain degree of flexibility in terms of childbearing. Improved social and economic conditions for women have therefore made it important for women to have control of their lives in terms of deciding whether or not to have children and when. In conjunction with the social and economic context of reproductive rights, the issue of abortion rights is also an issue of women's rights. Abortion is seen as a 'choice' to be respected, and as a positive condition of women's full self-determination. Given the availability of services, women are afforded the necessary conditions under which women can act on their decision concerning the termination of a pregnancy. Availability of abortion services continues to play an important role in the changing conditions for women. In states where women's economic status is high relative to men, there may be more pressure to assure that women have the option to consider abortion or motherhood in terms of their own needs.

Abortion Restrictions. The results show that the restrictiveness index has a negative effect on the 1982 provider rate. The negative influence of the restrictiveness measure is in the predicted direction. States with more restrictiveness laws have fewer services available.

There are two ways to interpret why the restrictiveness index was significant in 1982 and not 1976 (see Table 6.3). The first interpretation is a policy consideration. One purpose of using the

same measure in both regression models was, in part, to determine whether restrictions had an immediate influence on abortion services, or exhibited a lag between enactment and effect on abortion services. The indicator used was comprised of abortion laws passed between 1973 and 1975. The restrictiveness index was not included in the final 1976 provider rate model because of its weak effect on the preliminary analysis. This finding lends support to the position that abortion regulations take time to exert an impact.

It was also suggested that since abortion laws are in a constant state of flux, it would be best to view the restrictiveness index as a measure of restrictiveness climate. The second interpretation reflects the course of events in terms of abortion regulations. A significant event occurred between 1976 and 1982. The Hyde Amendment was passed in 1977, and eventually enforced by 1980. In Chapter 3, it was stated that one consequence of the Hyde Amendment was that its passage paved the way for tolerating restrictions on legal abortion. An overall atmosphere promoting regulations against abortion may have been the boost needed for state laws to be enforced and to have an impact. Based on this position, the findings suggest that a climate supportive of restrictions against abortion can influence the availability of abortion services by limiting the number of providers.

Role of health care system - Characteristics. Both characteristics associated with the existence of health care services have strong effects on the 1976 and 1982 provider rates but in opposite directions. The results show that the more physicians there are per population the higher the provider rate. The negative direction of

the relationship between percent metropolitan and the provider rate is opposite to that of predictions. It was expected that more services would be available in states where a large proportion of the population reside in metropolitan areas. Instead, the results show that more services are available in less urban states

There are two plausible interpretations of this negative relationship. One interpretation is in terms of efficiency of service delivery relative to population size; in urban states populations are more concentrated and can be served by a smaller number of providers. In a more rural state, more providers are needed to service a more dispersed population. The second explanation has to do with the geographic availability and type of provider. According to the Alan Guttmacher Institute, there has been a trend toward provision of services in large non-hospital facilities which are concentrated in large cities. Perhaps the negative relationship can be explained by the location of a few large abortion facilities in urban areas. The results raise the question of whether the relationship between percent metropolitan and the provider rate is dependent on the type of provider; for example, will the effects of urbanism differ for hospital and non-hospital facilities, or between small and large non-hospital facilities? These questions are pursued further in Chapter 7. Since a large number of abortions can occur in a relatively small number of large facilities, it is still expected that the abortion rate will be higher in states where a relatively large percentage of the population resides in metropolitan areas. The consistent results for the separate models indicates the continued importance of the

availability of physicians and urbanism (although in a negative direction) for the existence of providers.

Role of health care system - Demand for care. The 1976 provider rate responds to two characteristics frequently used to profile groups of women who obtain abortions: education and marital status. The positive relationship between the provider rate and marital status is in the predicted direction, whereas the positive effect of education is in the direction opposite of that predicted. In states where there is a high proportion of unmarried women in the population there are more providers. Similarly, states with a higher education level have more services available. Marital status is the only population characteristic included in the final model of the 1982 provider rate and it does not attain statistical significance. The results indicate that characteristics of the population with high utilization rates, and therefore a demand for services, have little relationship to the actual availability of services.

It has been well documented that unmarried women are more likely to have unintended pregnancies than married women, and that unmarried women are more likely to resolve an accidental pregnancy by abortion. According to Petchesky (1984), legal abortion has contributed to a changing consciousness among women that marriage and childbearing can be legitimately deferred to other goals and needs, without the deferment of sex. Existence and availability of services can be seen as a likely response to these expanded possibilities.

It was predicted that less education would be associated with a higher demand for abortion services. Based on previous research, it

was assumed that less educated women would not be as likely to have access to information and to abortion through a private physician (Henshaw & O'Reilley 1983). Instead the findings show a positive effect of education on the provider rate. In general, education goes hand in hand with approval for abortion. People with more education are most likely to approve abortion under varying circumstances. Education also tends to be associated with preferences for smaller families and for initiating childbearing at later ages (Henshaw & O'Reilley 1983). The desire for a smaller family, along with approval for abortion are conditions which make availability of services an important resource for deciding how to resolve unplanned pregnancies. Educated persons also have more access to resources in order to bring their demands into the public arena, and to achieve their desired goals.

Abortion Rates

The predictor variables account for 71% of the variation in the 1976 abortion rate, and 85% of the variation in the 1982 abortion rate.

Social Movement Activity. Social movement activity is included in the 1982 model of abortion rate and was not part of the 1976 model. The results show that anti-abortion movement activity is positively related to the abortion rate. This pattern is the same as that found with the 1982 provider rate. The findings are not supportive of the proposed hypothesis which expected that the abortion rate would be higher in states where pro-abortion activity was strong, and lower in

states where anti-abortion movement was more effectively mobilized. The reasons and explanation offered earlier hold for the relationship between social movement activity and the abortion rate. The effects of social movement activity on the availability and use of abortion services have yet to be determined adequately.

Lifestyle Differences. The religious orientation index and the measure of family presence showed negative effects on the 1976 abortion rate. States with a large proportion of their populations holding a fundamental orientation to the world have a lower abortion rate. Similarly, states with a higher percentage of families with their own children have lower abortion rates. The findings support the hypothesis which predicted that a cultural climate promoting traditional family and religious norms would give rise to pressures that would oppose abortions. The divorce rate has a small effect on the 1976 abortion rate. By 1982, the divorce rate and the measure of family presence have important effects on the abortion rate in the predicted directions. In states with a higher proportion of families with children there is a lower abortion rate. Concomitantly, in states with a higher divorce rate there is also a higher abortion rate. The religious orientation index has a weak effect on the 1982 abortion rate. The findings for both models of abortion rate lend support to the position that the cultural context of a state affect the utilization of abortion services.

The lifestyle difference interpretation suggests that the debate surrounding abortion is a protest to protect and promote a particular cultural position. The fundamental religious orientation index and

the indicator of family presence can be seen as reinforcing traditional views of the family and religion. Both factors reflect a community in which legal abortion represents a threat to those who cherish traditional religious and moral values. Abortion opponents tend to view abortion as a symbol of the loss of cultural support for traditional religious and moral values. In order to protect these values, groups who maintain a traditional image of the family and a fundamental religious orientation to the world, may create a climate in which the social constraints against abortion would be high. The impact of these constraints can be seen in a low abortion rate.

In the 1976 model of abortion rate, religious orientation is found to be an important explanatory factor, whereas the divorce rate was not included in the final model. By 1982, the divorce rate is an important element, and religious orientation has lost its impact. The different roles that these two factors play in the abortion rate models are representative of the changing nature of the abortion debate. After the 1973 Supreme Court decision, the abortion debate was dominated by religious and philosophical arguments regarding the status of the fetus. Petchesky (1984) noted that by 1981, public debates about fetal personhood had given way to questions about family structure and style. This shift away from religious themes toward family organization reflects fluctuations in many demographic patterns, such as a decreasing birth rate, a change in family structure as the traditional nuclear family image of the 1950's became a statistical minority, and an increase in the number of households with two wage earners (Markson 1982).

The impact of the divorce rate along with family presence on the 1982 abortion rate lends continued support to the position that the moral values upheld by a community can be strong enough to affect the behavior of its members. The divorce rate is symbolic of groups whose values are tolerant of nontraditional families. Such a climate is more accepting of abortion than a climate where traditional images of the family are strong. The findings suggest that the abortion rate is reflective of a particular cultural position regarding the family. In states where nontraditional family styles are accepted, there is a higher abortion rate; and, in states where values promote conventional views of marriage, there is a lower abortion rate.

Status of Women. The status of women index has a positive effect on the 1976 abortion rate, and wa not included in the 1982 model. The positive finding of the 1976 supports the assumptions underlying the feminist position of reproductive rights. One, is that the use of abortion services occurs within a context of relations between men and women. The second assumption is that the changes in the abortion rate are in response to existing economic conditions. In states where women's economic status is high relative to men, there is a higher abortion rate. The results suggest that women's position in society is an important determinant shaping the utilization of abortion services.

The diminished effects of the status of women index on the 1982 abortion rate suggests that the position of women is not as important for the use of services at it was earlier. However, the impact of women's status remains influential through its effect on the provider

rate which in turn influences the abortion rate.

Restrictions. The restrictiveness index was not included in either reduced model of abortion rates. In spite of the efforts to control abortion, history has shown that whatever the risks women will obtain abortions (Gordon 1976), The attempts to suppress abortion through funding limitations lends support to history, and shows that women will persist in getting abortions. In 1977, when the Hyde Amendment was initially enforced, it was predicted that low income women would suffer the most from funding limitations and would be unable to obtain abortions. Instead, several investigations found that the majority of Medicaid eligible women did indeed obtain abortions. The intentions to eliminate abortions through restrictive regulations have been unsuccessful.

Role of health care system - Characteristics. The physician rate and percent metropolitan have strong effects on the 1976 and 1982 abortion rates. The effect of urbanism shifts direction with the abortion rate, now being in the predicted direction. The results support the hypothesis which stated that regardless of the social and political controversy surrounding abortion, characteristics associated with the provision of health care services influence the utilization of abortion services. In states with a large concentration of physicians there is a higher abortion rate. Similarly, a more urban state will have a higher abortion rate that a less urban state. In comparing the beta coefficients between the two models, the importance of the physician rate increased over time, and the effect of urbanism decreased slightly.

Clearly, characteristics associated with health care services play a crucial role in the utilization of abortion services. The uneven use of abortion services is similar to the uneven distribution of health care services in general. Similar to other health care services, the distribution of physicians affects the use of services. Of course, the groups of women who suffer from the uneven distribution of abortion services are the young, poor and rural women.

The findings are not surprising given that abortion as a procedure falls within the jurisdiction of the health care system. However, the characteristics associated with the adequate provision of health care services are not the only determinants of abortion services. The findings show that when the effects of urbanism and the physician rate are controlled, other factors such as political concerns, moral climate and the status of women affect variations in the use of abortion services.

Role of the health care system - Demand for care. Characteristics of high demand populations needing abortion services, as indicated by percent black and percent of women of childbearing ages in the population are significant determinants of the 1976 and 1982 abortion rates in the predicted direction. The results show that a state with a large black population will have a higher abortion rate. The results also indicate that the abortion rate is higher in states with a high proportion of women age 15-44. Education also has an important effect on the 1982 abortion rate, but not in the predicted direction. It was predicted that less education would be associated with higher abortion rates, since women with little education may experience

difficulties obtaining abortion because of low income or other factors (Henshaw & O'Reilley 1983). Instead, the results show that states with higher education level have a higher abortion rate.

The findings pertaining to racial composition support the literature which has shown that nonwhite women have a higher abortion rate than white women. The relationship between women of childbearing age and the abortion rate is straightforward, since the variable is a measure of the age span in which women are most fertile and likely to become pregnant. The positive association for percent black and proportion females of reproductive age supports previous profiles of users and reflects the groups of women with the highest utilization rate.

By 1982, median education level is positively associated with the abortion rate. The positive effect for education indicates that, net of other factors, such as racial composition and proportion of women of childbearing ages, the abortion rate is higher in states with a higher median education level. This finding is not consistent with previous research findings which suggest that for individuals more education is associated with lower abortion rates, since education is linked with access to information, access to abortion through a private physician, and effectiveness in the use of contraceptives. One possible explanation is that legal abortion may provide alternatives for women so that they can receive the benefits from their education, probably in the shape of their occupational choices. Another possible explanation for the positive effect of education may be found in the conceptualization of this measure. Perhaps a variable

indicating the education level of females of certain age groups would be more telling about the relationship between education and the abortion rate

Abortion Providers. The provider rate is a strong determinant of the 1976 and 1982 abortion rates. This finding supports the hypothesis, and shows that availability of abortion services has an important effect in the utilization rate. It was surprising to find that the direct effect of the provider rate on the abortion rate was not larger. Comparing the standardized beta coefficients in Table 6.4, it can be seen that the physician rate and percent metropolitan, both measures of the characteristics associated with the existence of health care services, have stronger effects on the abortion rate than the provider rate. In the later model, only the physician rate has a stronger effect than the provider rate.

The substantial impact of the provider rate on the abortion rate is consistent with expectations. The finding is also consistent with previous research which suggests that the availability of services has a substantial effect on the utilization of services (Hout 1977).

It is worth remembering that other factors also have a strong effect on the abortion rate, especially characteristics associated with the role of the health care system. Thus, while availability is a major determinant of the abortion rate, it is by no means the only important factor. Based on the findings, interpretations concerning the importance of availability to the use of abortion services must be couched in a context of moral climate, social movement activity, and limitations of the health care system itself.

Summary

This section examined the influence of the five components of the abortion issue on both the availability and use of abortion services. The variables remaining in the final estimations of the models provides support for all five of the factors hypothesized to effect availability and use of abortion services. In other words, no one way of understanding the abortion issue is the key to providing answers about the uneven distribution of abortion services.

There were consistent patterns as well as differences between the two rates and across years. Anti-abortion movement activity had a positive influence on both the provider rate and abortion rate. Several suggestions were given to explain this unpredicted result. Most notably, better measures of social movement activity are needed to determine the impact of social movements on abortion services. The variables measuring cultural climate showed different effects among the models. The distinctive feature to be gained from these results is that the cultural context is important determining whether services are available and whether they are used. In general, the divorce rate showed a consistent positive effect on the provider rate, whereas the measure of family presence exhibited a negative relationship with the abortion rate. The consistency of these two measures suggest that the cultural climate reflects strongly held values, such as views about the family. This climate in turn creates enough pressure to encourage or discourage the availability and use of abortion services. The impact of status of women appears more important for availability of

services rather than the abortion rate. This is not surprising given the feminist position on reproductive rights. Feminists, on the whole, have taken the initiative in making substantial changes in the quality and conditions of abortion care and for emphasizing the importance of women's rights and 'choice' for all women. The extent to which services are available reflects the availability of choice for women to decide whether or not to terminate a pregnancy. In states where the economic position of women is high relative to men, more services are available. The influence of abortion regulations was limited to the 1982 provider rate. Attempts to control abortion through restrictions has little influence on the utilization of abortion services. Characteristics measuring the role of the health care system had the strongest effects on the provider rates and abortion rates. Similar to other health care facilities, practitioners and urbanism are important for the availability and use of abortion services. The effects of the variables measuring the demand for care by those who are need of abortion services were inconsistent. The different findings may reflect inadequacies in the conceptualization of the groups of women who potentially need and use the services. Instead of using homogeneous rates of the population, it was suggested that using more theoretically meaningful rates would provide better information about the relationship between responsiveness of the health care system to those women who have need for the services. As expected, availability of abortion services was a strong determinant of variations in state abortion rates.

Overall, a combination of social and moral conditions and aspects

of the health care system were important determinants of the 1976 provider rate and abortion rate. By 1982, the provider rate was more responsive to the political climate and concerns than the other models, as witnessed by the combined effects of the status of women index, abortion regulations, anti-abortion movement activity and the weak relationship with demand characteristics from groups who potentially have need to use them. When compared to the other models, the predictor variables accounted for the least amount of variation in the 1982 provider rate. The consistent effects of the status of women index and the divorce rate suggest that availability of services is more responsive to the sentiment of 'choice' rather than pronouncements about the wrongness of abortion. In an atmosphere that encourages a view of abortion as a decision, there will be more services available. In Chapter 7 the variation in the 1982 providers is explored in more detail by examining the different types of providers.

In the final section of this chapter the influence of several components of the abortion issue are tested by using a pooled cross-sectional and time series data structure. Since data are available for two periods of time, it was decided to see what picture of abortion services would emerge by capitalizing on both longitudinal and cross-sectional variation.

POOLED TIME SERIES AND CROSS SECTION DESIGN - ANOTHER METHODOLOGICAL CONSIDERATION

The availability of two time periods lends itself to the consideration of a second way to analyze this data set and take advantage of both the longitudinal and cross sectional dimension- pooling of cross section and time series data. The data are arranged by observations on N cross section units over T periods of time (Kmenta 1971). Instead of having two separate analyses with 50 observations in each, I now have 100 observations (50 (states) X 2 (time periods) = 100) in a single analysis. A special feature of the pooled cross section and time series data structure is the use of cross sectional (between unit) variation and longitudinal (within unit) variation to estimate causal parameters (Hannan & Young 1977). Such a research design permits the study of causal forces across several cases where the cause may appear at different times and in different cases (Stimson 1985).

Ordinary least squares (OLS) regression analysis is the easiest and best- known way to analyze pooled data. Unfortunately, estimation problems arise due to the likelihood that the errors will be correlated, and therefore produce results that are inefficient. Use of OLS is based on assumptions that the variances of the residuals are constant, and the residuals are uncorrelated. However, with pooled data the units are not independent over time, and each unit does not provide completely new information. Hence, correlated errors are possible both over time and between cross sections. If the residuals

are correlated and heteroskedastic, then the standard errors, based on the variance of the error terms, will be biased. Therefore, standard statistical tests will be inaccurate since the estimated variance will be biased (Hanushek & Jackson 1977). The OLS estimator is unbiased, but inefficient with biased standard errors. In effect, OLS does not recognize the pooled structure of the data; it ignores the structure of N units over T times (Stimson 1985).

The goal is to obtain efficient estimates of the regression coefficient and of their variances. There are other estimation procedures besides OLS that can deal with these problems. These models differ in the assumptions made about the error term and the nature of the source of serial dependence. Two such procedures include least squares with dummy variables (LSDV) and estimation of the error components.

The LSDV model assumes that the error consists of between unit (state specific) and time specific components, as well as a random error term. One remedy is to introduce state and time dummy variables. The between unit and time specific components are modeled into the equation as fixed effects. A system of dummy variables for time and unit are introduced into an OLS model. In this research, the state specific effect would be represented by 49 dummy variables - one for each state (50-1=49) - and 1 dummy variable for the time specific effect (2-1=1). The LSDV approach assumes a different intercept for each cross section and each time period. In essence, the coefficient for each dummy variable is taken as an estimate of a fixed parameter (Berk, Hoffman, Maki, Rauma & Wong 1979). Two difficulties commonly

associated with this approach include 1) high collinearity between explanatory variables and dummy variables which have no theoretical meaning, and 2) loss of degrees of freedom with large sets of dummy variables (Stimson 1985).

A second approach to analysis of pooled data is the error components model. In contrast to the LSDV approach, the error components model does not assume fixed effects for the between and within error variance. The state and time effects are treated as random variables and estimated as part of the error term. This model assumes that the error term can be estimated for each unit, and then included in a regression equation. This procedure is commonly referred to as generalized least squares (GLS). The error components solution corrects the bias of the OLS error term with an estimator that specifies the bias. The error term is partitioned into three components - total, between and within. In essence, partitioning the error term assumes constant autocorrelation within each unit, and therefore no serial correlation (Stimson 1985). The assumption that error components are constant across years within states is realistic for short time spans. However, given a time dominant design, this restriction would be difficult to satisfy. The estimation model is therefore appropriate when research interests are concerned with unit effects, such as this one.

The procedure used with this data was actually a modified version of the GLS model - weighted regression analysis. A true GLS model estimates the error terms from the error covariation matrix and creates error estimates within each state over time. This procedure

accounts for both autocorrelation and heteroskedasticity, and assumes constant autocorrelation between states over time. This is a fine procedure when there are more than two time periods (and computer software is available). Two time periods makes a rather short time series. Before making assumptions about autocorrelation, it was decided to investigate the effect of time on the pooled data set. Preliminary tests were conducted to see whether time had a strong enough effect to warrant pooling the data. If time had a strong enough effect, then it would be best to keep the data as two separate data sets. The results from the preliminary tests showed no significant effect of time. Therefore, it was decided to pool the data and to treat time as a fixed effect by creating a dummy variable for year. The next issue to resolve was heteroskedasticity, unequal variances of the error terms. Heteroskedasticity is often a problem with cross sectional data, and most frequent where the units of observation differ in scale or size, such as states. The problem of heteroskedasticity is magnified when two cross section data sets are pooled together. Examination of the scatterplots of the residuals showed a distinct pattern between the residuals and percent metropolitan. This indicated that the effects of states like New York with a large percentage of the population residing in metropolitan areas became inflated when added to the data set a second time. In order to correct for the uneven effect of percent metropolitan, a regression analysis was computed with a weighted estimator of percent metropolitan. In cross sections across states some type of population variable is often used as a weight. The estimator for this type of

analysis is equal to the reciprocal of the square root of the variable. Weighted data are then computed by multiplying the original data by one over the square root of the weight. The weighted regression coefficients are ordinary least square coefficients for the regression with weighted data. The weighted regression does not include a constant per se, but the corresponding variable is the square root of the weighted variable.

Results

Table 6.5 shows the correlations for the pooled data. The results from the weighted and un-weighted regression analysis are presented in Table 6.6. The table presents the regression coefficients and standard errors for both the weighted and un-weighted independent variables, and allows for the comparison of the standard errors between the two types of analysis. Equations are estimated for the provider rate and abortion rate. Variables from two of the five components were dropped from the pooled analysis. The restrictiveness index was not included because the same measure was used for both years. Social movement indicators were also discarded since they were available for one year. Each equation contained the same ten independent variables and one dummy variable for time (0=1976 and 1=1982). The time dummy variable was significant for the provider rate and not the abortion rate. The provider rate was estimated as an independent variable in the abortion rate models.

In terms of the adjusted R-squares, the variables associated with the pooled models fall between the adjusted R-square values for the separate OLS models. The predictor variables account for 54% of the

TABLE 6.5 Intercorrelations of Pooled Measures of Abortion Issue, Provider Rate, and Abortion Rate.

	2	3	4	5	6	7	8
1. Religous Orientation	-.182	-.253	-.155	.177	.190	.418	.428
2. Families		.044	-.166	-.266	-.258	-.127	-.437
3. Divorce			.052	-.306	-.034	-.082	-.280
4. Status of Women Index				.315	.110	-.175	.359
5. Physicians					.633	-.079	.663
6. Metropolitan						.182	.495
7. Black							.324
8. Unmarried							
9. Education							
10. Females							
11. Year (Dummy Variable)							
12 Abortion Rate							
13. Provider Rate							

	9	10	11	12	13	MEAN	STD DEV
1. Religous Orientation	-.491	-.113	-.037	.077	-.208	0.00	0.47
2. Families	.293	.243	-.269	-.281	.167	53.30	3.30
3. Divorce	.174	.229	.037	.091	.364	5.58	2.27
4. Status of Women Index	.238	.484	.631	.381	.374	0.00	0.70
5. Physicians	.315	.314	.223	.740	.278	162.21	42.30
6. Metropolitan	.139	.266	.064	.680	.005	59.84	24.01
7. Black	-.665	.093	.010	.109	-.291	9.05	9.20
8. Unmarried	-.169	.373	.542	.582	.051	41.61	3.28
9. Education		.278	.033	.280	.482	12.48	0.18
10. Females			.559	.470	.358	0.23	0.01
11. Year (Dummy Variable)				.264	.083	0.50	0.50
12 Abortion Rate					.460	21.68	8.58
13. Provider Rate						5.62	4.01

TABLE 6.6 Weighted and Un-Weighted Regression Estimates of Pooled Measures of Abortion Issue on Provider Rate and Abortion Rate.

	Weighted				Un-Weighted			
	Provider Rate		Abortion Rate		Provider Rate		Abortion Rate	
	b	s.e.	b	s.e.	b	s.e.	b	s.e.
Religious Orientation	-0.52	0.82	-0.06	1.12	-0.15	0.82	-0.62	1.13
Families	0.19*	0.14	-0.53*	0.19	0.17*	0.13	-0.59**	0.18
Divorce Rate	0.99**	0.17	0.19	0.27	0.87**	0.16	0.27*	0.25
Status of Women Index	1.35**	0.56	0.64	0.79	1.86**	0.57	0.38	0.84
Physician Rate	0.05**	0.02	0.05**	0.02	0.04**	0.01	0.07**	0.02
Metropolitan	-0.07**	0.02	0.11**	0.03	-0.07**	0.02	0.11*	0.03
Black	0.00	0.05	0.14**	0.06	0.00	0.05	0.20**	0.07
Not Married	0.33*	0.17	0.09	0.24	0.31*	0.19	0.11	0.27
Education	3.10*	2.73	7.14*	3.71	5.01*	2.99	4.82*	4.19
Females	39.77	47.18	155.33**	64.04	19.94	45.44	150.79*	62.75
Year (Dummy Variable)	-2.48**	0.97	-0.87	1.36	-2.80**	1.03	-1.37	1.48
Provider Rate			0.48**	0.15			0.64	0.15
Adjusted R^2	0.54		0.79		0.50		0.79	

* = Value greater than the standard error
** = Value greater than twice the standard error

variation in the provider rate, and 79% of the variation in the abortion rate.

The variables which have the strongest effects on the provider rate are the divorce rate, status of women index, the physician rate, percent metropolitan, and family presence, percent married, and median education have weaker effects. All in all, fewer measures of social climate had effects on the abortion rate. The variables which have the strongest effects on the abortion rate are family presence, both characteristics associated with the existence of health care facilities, percent black, proportion of females age 15-44, and the provider rate, followed in importance by median education.

In general the two pooled models reflect the combined effects of the four separate models. What was significant on the 1976 model of the provider rate and the 1982 model was again significant in the pooled model. If a variable was significant in one year but not in the other, it was significant in the pooled analysis. The same pattern of results held true for the abortion rate with one exception. The divorce rate, which showed weak effect in the 1976 abortion rate and a relatively strong effect on the 1982 abortion rate, has virtually no effect in the pooled model. None of the effects of the variables changed directions. A good example of the pooled 'behavior' of the variables is the measure of family presence. In the separate models, this variable had a positive effect on the 1976 provider rate, no effect on the 1982 provider rate, and a negative effect on both the 1976 and 1982 abortion rates. In the pooled model, family presence is positively associated with the provider rate, and negatively related

to the abortion rate.

The statistical fascination in estimating the provider rates and abortion rates as separate OLS regression equations, pooled weighted and pooled un-weighted regression equations lies in watching the changes variables undergo to retain their effect. The results from the weighted pooled cross-section and time series analysis were not as anticipated. Statistically, the weighted and un-weighted standard errors were similar to one another. Since the un-weighted coefficients are biased, it was expected that the weighted standard errors would be sizeable different from the un-weighted standard errors. The major advantages to the pooled model is that conclusions are easier to reach and are clearer. The repetitiveness of the results is gone, and it becomes easier to see what factors are important over time in influencing the availability and use of abortion services. For example, the divorce rate was a significant factor in the separate provider rate models, and had an important effect on the 1982 abortion rate but not on the 1976 model. Its weak effect in the pooled model of the abortion rate suggests that values supportive of nontraditional families is less important for utilization of services and more important for the availability of abortion facilities.

CONCLUSIONS

What conclusions about abortion services emerges from all these

regression analyses? The picture is that the different meanings given to the abortion issue are factors which help account for the uneven distribution of abortion services. Abortion is unique. One of the strongest and most consistent findings was the impact of the health care system on the availability and use of abortion services. However, unlike other health care services, the demand for the legalization of abortion and the provision of services require a political and administrative solution to what is a moral and social issue. One effect of this complex relationship is demonstrated by the finding that abortion services are subject to special pressures for providing services that are legal.

Two other findings appear important. One is the dominant effect of the provider rate on the abortion rate. Second, the findings show that when moral values and lifestyle differences are strong enough, they can effect whether services are available or not, and whether they are used. The dominance of the effect of the provider rate on the abortion rate suggests that increasing the availability of providers would decrease state variation in the abortion rate. However, consideration of how to make services available is complex given that the cultural climate, status of women, political pressures, and the health care system are crucial determinants of availability. Together, the results suggest that increasing availability is not merely a matter of locating a good network of health care facilities, organized by the state or private sector as suggested by Lowenduski and Outshoorn (1986). Interpretations about availability and use of services must account for the linkages between moral climate,

political processes and limitations of the health care system. The policy implications of this complex relationship are discussed in Chapter 8.

In the next chapter variations in the types of providers are explored and discussed. Research on abortion providers has usually focused on one type of provider, or has looked at all providers without taking differences into account. Since the results from this chapter indicate that abortion services are affected by various social and political structures and values, it seems reasonable to further inquire whether these factors similarly affect the different types of abortion services.

Chapter 7

TYPES OF PROVIDERS AND THE FIVE COMPONENTS OF ABORTION

Abortions take place in several types of settings, such as private hospitals, public hospitals, specialized abortion clinics, and private physicians' offices. All play an important role in making abortion services available to women. After the 1973 judicial decision abortions were primarily performed in hospital settings, which were regarded by many as the safest setting. Soon it became apparent that many hospitals were not going to provide services. A combination of forces contributed to the response by existing institutions to the legalization of abortion: the growing visibility of abortion as a 'hot potato' issue, variations in hospitals' organizational and structural factors and attitudes of medical staff members toward fertility control and abortion, a social atmosphere which tolerated regulations, and a change in procedure where abortions could safely be performed as an outpatient service. The growth of non-hospital facilities was the response to the reduction in the number of hospitals offering services. Despite the decline in numbers, hospitals remain important providers of abortion services. Public hospitals, especially, are the principle source of medical services for the poor. The failure of public hospitals to provide abortions affects a part of the population which often lacks resources to obtain abortions elsewhere. According to Henshaw, Forrest & Blaine (1984), in 1982 hospitals accounted for less than 50% of the facilities where

abortions are performed, and 82% of all abortions were obtained in non-hospital settings, an increase of 43% since 1973 .

One theme throughout this research is that the availability and use of abortion services is the result of an interplay of forces among the moral climate, prevailing political processes, and constraints by the health care system itself. In Chapter 6 it was shown that a combination of various social and political structure and values differentially affect abortion providers and the abortion rate. It seems reasonable to inquire further as to how these factors affect the different types of abortion services. Possibly states which have restrictive abortion regulations also have a higher clinic abortion rate and fewer abortion performed in hospitals; or, since urban areas generally have more health care facilities than rural areas, it may be that urbanization is positively associated with availability of non-hospital facilities. Since little research has been done comparing the different types of abortion providers, this part of the dissertation is exploratory in nature.

In the next section results from the ordinary least squares (OLS) regression analyses are reported and discussed. Three types of providers, as identified by the Alan Guttmacher Institute, are used in the analysis: hospitals (private and public), large non-hospital facilities performing 400 or more abortion per year, and small non-hospital facilities performing fewer than 400 abortion per year. The models were estimated for one year only - 1982. Using 1982 data allowed the measures of social movement activity to be included in the models. The terms 'large' and 'small non-hospital facilities' are

used instead of 'clinics' and 'physicians' offices', respectively. The use of the former terms follow the conventions used by the Alan Guttmacher Institute and are more accurate descriptions of the types of facilities offering abortion services. For example, larger physician practices reporting at least 50% of their patient visits are made for purposes of abortion may be categorized as a large non-hospital provider. I chose to follow the current practice by the Alan Guttmacher Institute.

There are two parts to the analysis of the different types of providers. In the first part, the results from three regression equations based on three different dependent variables are discussed: hospital provider rate, large non-hospital provider rate, and small non-hospital provider rate. The same independent variables included in the regressions for the 1982 provider rate model (Chapter 6) are in the regression analyses. The findings are summarized with the emphasis on the statistically significant variables; that is, variables with a regression coefficient larger than its standard error. In the second part, the effects of the different types of providers on their respective abortion rates are explored. The dependent variable for each equation is the abortion rate corresponding to the type of provider. For example, in the equation where the independent variable is the number of large non-hospital facilities per 100,000 women of reproductive age, the dependent variable is the percent of abortion obtained in large non-hospital facilities, and so forth for hospitals and small non-hospital settings. In essence the purpose of this portion of the data analysis

is to look at the effects the different providers have on the abortion rate.

The interrelationship among the different types of abortion services and the five components reflecting the various aspects of the current abortion issue are examined in this chapter. No formal hypotheses are tested.

Before presenting the results, it is worth explaining some changes in terminology. The rate variables used as dependent variables in Chapter 6 are referred to as 'total provider rate' and 'total abortion rate'. In this chapter the distinction is made among 'provider specific provider rates' and 'provider specific abortion rate' versus 'total provider rate' and 'total abortion rate'. Also, the word 'facilities' is used frequently and is interchangeable with the word 'providers.' Thus, three types of providers are examined in this chapter: hospital facilities, large non-hospital facilities, and small non-hospital facilities. Together, the rates based on these categories are 'provider specific' rates.

AVAILABILITY OF DIFFERENT ABORTION PROVIDERS

Table 7.1 shows the correlations among the independent variables, the rates for the three types of providers, and the total 1982 provider rate. The results from the regression analyses are presented in Table 7.2. Overall, the model was a good predictor of large non-hospital facilities, accounting for 50% of the variance, followed by

TABLE 7.1 Correlations of Measures of Abortion Issue with Three Provider Specific Provider Rates, and Total Provider Rate, 1982.

	Hospitals	Large Non-Hospitals	Small Non-Hospitals	Provider Rate
Anti-Abortion Movement	-.20	.23	-.15	-.17
Pro-Abortion Movement	-.05	.45	-.00	.02
Religous Orientation	-.22	.05	-.23	-.25
Families	.11	-.34	.24	.18
Divorce	.12	.20	.38	.33
Status of Women	.30	.06	.46	.45
Restrictiveness	-.22	-.31	-.21	-.28
Physicians	.24	.22	.11	.21
Metropolitan	.01	.34	-.09	-.02
Black	-.13	-.02	-.36	-.30
Unmarried	.12	.21	-.13	-.01
Education	.31	.20	.49	.49
Females	.40	-.00	.37	.43

TABLE 7.2 Regression Estimates of Measures of Abortion Issue on Three Provider Specific Provider Rates, 1982

	Hospitals			Large Non-Hospitals			Small Non-Hospitals		
	b	s.e.	Beta	b	s.e.	Beta	b	s.e.	Beta
Anti-Abortion Movement	0.23	0.62	0.06	0.47*	0.12	0.49	0.96*	0.81	0.16
Pro-Abortion Movement	0.00	0.91	0.00	-0.09	0.18	-0.07	0.60	1.20	0.08
Religious Orientation	-1.01*	0.82	-0.24	0.00	0.16	0.00	0.32	1.06	0.05
Families	-0.05	0.16	-0.08	-0.05**	-0.03	-0.36	0.24*	0.21	0.27
Divorce Rate	0.14	0.18	0.15	0.06	0.04	0.30	0.66*	0.24	0.51
Status of Women Index	0.31	0.62	0.09	-0.09	0.12	-0.12	1.66**	0.79	0.33
Restrictiveness Index	-0.03	0.03	-0.14	-0.02*	0.01	-0.34	-0.04*	0.04	-0.13
Physician Rate	0.01	0.02	0.17	0.00	0.00	-0.27	0.02*	0.02	0.32
Metropolitan	-0.04**	0.02	-0.43	0.00	0.00	0.07	-0.06**	0.02	-0.44
Black	-0.01	0.05	-0.05	0.00	0.01	0.07	-0.03	0.07	-0.10
Unmarried	0.24*	0.19	0.41	0.05*	0.04	0.36	0.22	0.25	0.25
Education	1.03	3.06	0.10	1.13*	0.59	0.45	1.87	3.98	0.12
Females	68.46*	52.98	0.33	2.86	9.96	0.06	1.53	67.51	0.00
Adjusted R^2	0.14			0.49			0.38		

* = Value greater than the standard error
** = Value greater than twice the standard error

38% of the variance of small non-hospital facilities, and 14% of hospital abortion services.

Social Movement Activity. Anti-abortion activity has a positive effect on both large and small non-hospital facilities, and a weak effect on hospital facilities. Pro-abortion movement activity shows virtually no effect on the different providers. The findings support previous research on harassment of abortion providers. Forrest and Henshaw (1987) found that reports of harassment were greatest among health care facilities whose primary service was abortion care. Pressure against non-hospital facilities was found to be greater than pressure directed at hospitals. Among non-hospital facilities, large facilities were more likely targets of anti-abortion activity than facilities performing fewer than 400 abortion per year. Comparing the beta coefficients in Table 7.2, it can be seen that anti-abortion movement activity is a stronger determinant for large non-hospital facilities than for smaller providers of abortion services. The findings show that where anti-abortion harassment is greater, there are more non-hospital facilities.

Lifestyle differences. The variables used to measure cultural climate show distinct relationships with different providers. The pattern for the variables measuring lifestyle differences varies for all three types of abortion providers. Hospital abortion services is the only model in which the religious orientation index plays an important role. Family pressure and the divorce rate have weak effects on hospital facilities, and strong effects on both types of non-hospital facilities. The family presence coefficients shifts

direction depending on the type of provider; negative with large non-hospital facilities and positive with small non-hospital ones. The divorce rate maintains a strong positive effect on both large and small non-hospital facilities.

The results show that in states where fundamentalist religious values are strong there are fewer providers. In general, the strong effect of fundamental religious values can be expected to have the most influence on hospitals, especially public hospitals, which are believed to be more easily influenced by community norms and public opinion (Henshaw, Forrest & Blaine 1984; Bond & Johnson 1982). Hospitals also respond to norms within the organization that are set by hospital administrators and physicians. Since 1973, public institutions and individuals have also been exempted from being 'forced' to provide abortion services which were against their moral or religious views. More specifically, it is not surprising to find the negative relationship between religious orientation and hospital abortion services since many private hospitals are Catholic hospitals.

Whereas a strong fundamentalist religious orientation has an effect on hospital providers, non-hospital providers are more responsive to conventional family values. As an indicator of family presence, the results show that in states where traditional values regarding the family are strong, there are fewer large non-hospital facilities. It makes sense that a newly created system of large specialized abortion clinics would not be welcomed in a community with strong family values. Afterall, the development of large non-hospital facilities was in response to the lack of services offered by traditional health

care services. The reluctance of existing health care institutions to offer abortion services may have mirrored the sentiment of the community. The results suggest that community sentiment can be strong enough to exert pressures which dissuade the availability of large non-hospital facilities. In contrast to large non-hospital facilities, the measure of family presence showed a positive effect on small non-hospital facilities. This positive relationship was found between family presence and the 1976 provider rate. It was suggested that the positive relationship may have been indicative of the proximity between families with children and health care services in general. Families tend to use private physicians for their health care needs. The confusion here may be the overlap of health care services with the more specialized services for abortion care. Small non-hospital facilities tend to be physicians' offices which offer various health care services and have regular patients. This positive effect may be reflective of the type of services more frequently used by families than the conflict between cultural values regarding the family and the availability of abortion services.

The divorce rate reflects groups whose values are grounded in the rights of individuals and the family as an institution responding to changing social and economic conditions. The positive relationship between the divorce rate and the existence of non-hospital facilities reflects the acceptance of a new set of institutions in response to the unwillingness of existing health care institutions to provide abortion. The findings suggest that services are more available in an atmosphere that encourages a view of abortion as a 'choice'.

Status of Women. The status of women index showed a strong influence on the availability of small non-hospital facilities, and has weaker effects on hospital and large non-hospital facilities. In states where there is a high degree of economic equality relative to men, there are more small non-hospital facilities. The weak relationship between hospitals and status of women is not surprising given that feminists and abortion activists were instrumental in the creation of non-hospital clinics to meet people's needs as hospitals continued to refuse abortion services. However, it is surprising that the status of women showed a weak relationship to large non-hospital facilities. This weak effect may be understood within the context of abortion services in 1982. The growth of abortion clinics was due in part to the lack of response by existing medical institutions to increasing demand and in response to the feminist cry for changes in reproductive health care. In many respects, the pleas by feminists had been met. By 1982, the existence of large non-hospital facilities had become an established source for abortion services, and many such facilities are beginning to offer a range of reproductive health care as well. The rival set of institutions met people's needs, and did so at a lower cost (Petchesky 1984).

Perhaps the positive relationship between status of women and small non-hospital facilities can be explained in terms of income and preference. The measure of women's position used in this study is a measure of gender equality on an economic dimension. The findings show that in states where women's economic status is high relative to men have more services available in small non-hospital facilities,

such as physicians' offices. In general, the cost of abortion is higher in small non-hospital facilities than the other types of facilities. Perhaps where women have a relatively high income, obtaining abortion in smaller facilities is more readily affordable. Also, for many middle and high income women there is a tendency with age to shift their source of reproductive health care from low costs clinics to private gynecologists. This positive relationship may reflect the changing preferences of feminists growing older.

Restrictions. In Chapter 6 the results showed that the restrictiveness index had a negative effect on the 1982 provider rate. Examination of provider rates by specific type of provider shows that abortion restrictions is an important factor for both large and small non-hospital facilities, and has a minor effect on hospital providers. States with more regulations have fewer non-hospital facilities. The findings show that abortion laws impose real limits on the availability of non-hospital providers.

One reason for the rapid growth of non-hospital facilities was the inadequate response of traditional health care providers to the change in the legal status of abortion. Although non-hospital facilities serve a needed and necessary function, it may not seem worthwhile to offer services where there is a strong climate of restrictiveness. Small facilities, which are usually physicians' offices, tend to have the option to eliminate the provision of abortion services and continue to provide other health care services. For large non-hospital facilities, however, the effect of abortion regulations may be more detrimental since large facilities primarily focus on

providing abortion care. Many clinics have been expanding to offer more comprehensive reproductive health care.

Role of health care system - Characteristics. The strong pattern that emerged between providers and characteristics associated with the delivery of health care services in Chapter 6 was repeated only for small non-hospital providers. The physician rate shows a strong positive relationship with small non-hospital providers and had a weak effect on hospitals and large non-hospital facilities. In states where the physician rate is high, there are more small non-hospital providers. Since small facilities are generally physicians' offices, it is easy to understand the positive impact of the physician rate on availability of small non-hospital facilities. Although the relationship between large non-hospital providers and physician rate was not strong, the direction was negative. Perhaps large facilities are served by a smaller number of physicians. Also, in many states licensed health care practitioners are able to perform abortion procedures, and the services of a trained physician are not required.

The measure of urbanism has a strong negative effect on hospital providers and small non-hospital facilities, and virtually no effect on large non-hospital providers. The negligible relationship may be attributed to the fact that there are too few large providers in relation to the measure of urbanism. The explanation offered in Chapter 6 about the efficiency of service delivery seems appropriate in understanding the relationship between urbanism and abortion services in hospitals. In urban states populations are more concentrated and can be served by a smaller number of providers than a

rural state where a more dispersed population needs to be served. The negative relationship between percent metropolitan and small non-hospital facilities leads to a different explanation. The findings suggest that small non-hospital facilities are more prevalent in less urban states. The results support Jaffe, Lindheim & Lee (1980), who reported that in smaller cities and rural areas an increasing number of doctors are offering abortion services in their offices. The ability of smaller facilities to provide services to a more dispersed population can be seen as a possible solution to the lack of abortion services outside metropolitan areas. A disadvantage to this type of service distribution is that the average amount paid for abortions is higher in small non-hospital facilities than larger ones. Thus, financial factors would remain a barrier women in rural areas.

Role of health care system - Demand for care. The four variables used to profile groups with high demand for services showed different patterns depending on type of provider. Percent black has a minor effect on all three types of providers. As suggested in Chapter 6, this negligible effect may be due to the need for a more conceptually meaningful variable to tap into the various effects of availability of abortion facilities in relation to the black women in need of services. For hospital providers, percent unmarried and proportion of females of childbearing ages has positive effects. Percent unmarried also helps to explain availability of large non-hospital facilities, along with median education. The lack of effect of population characteristics for small non-hospital facilities suggests that availability of services by that type of provider is not necessarily

responsive to groups of women who potentially have a need to use them.

Unmarried women are more likely than married women to have unintended pregnancies and to resolve them by abortion. Therefore, the availability of services, whether in hospitals or large non-hospital facilities is important to this group of women.

The relationship between hospital providers and proportion of women aged 15-44 is straightforward. Women of reproductive age are likely to use hospitals for other health care services, not just abortion services.

The positive effect of education on large non-hospital facilities mirrors the relationship between education and the 1976 provider rate. Education can be seen as a resource in helping women cope with an unplanned pregnancy. Jaffe, Lindheim and Lee (1980) reported that women who use clinics are different from women who use hospitals. Most notably, clinic's clients are more likely to be middle class and better educated. In contrast, public hospitals provide abortion care primarily to the poor.

Measures of population characteristics were too inconsistent to discern a pattern. Part of the inconsistency may be due to the use of large, homogeneous rate variables to estimate the effects on a more limited and focused aspect of abortion services. The diverse pattern does suggest the need for a theoretical guide and further research comparing the responsiveness of different facilities to the needs of various groups of women.

Summary

By examining the variables that affect the different types of

abortion facilities, a more refined picture emerges of the interrelationship of factors influencing availability of services than from the investigation of the total provider rate. For instance, the status of women index had a strong effect on the 1982 provider rate. When the provider rate was broken down into different types of facilities, the index had weak effects on hospital and large non-hospital facilities and a strong effect on small non-hospital abortion services. Given that feminists and abortion activists were responsible for setting up alternatives to meet the needs of women, this finding was unexpected. It was suggested that by 1982, large non-hospital facilities had become an established source of abortion services, and that possibly the relationship reflected the income level of women in the state and a shift in preferences in older women for private gynecological health care.

Indicators from other components exhibited similar tendencies, such as the measures of cultural climate and characteristics of the health care system. Results from the total 1982 provider rate model showed the divorce rate to be the only important indicator of lifestyle differences. However, in this chapter all three measures are influential depending on the type of provider. These findings reinforce and add depth to the results from Chapter 6 which showed that when moral values and lifestyle preferences are strong enough, they can affect the availability of certain types of abortion services. In terms of characteristics associated with the existence of health care services, the physician rate and percent metropolitan have weak effects on large non-hospital facilities. The physician

rate has a strong effect on small non-hospital providers, and percent metropolitan shows a negative influence on hospitals and small non-hospital facilities.

The results from this portion of the analysis show that cultural climate, social and political conditions, and the health care system differentially affect the availability of abortion services. In general, it appears that non-hospital facilities are more responsive to the social and political components than hospital abortion facilities. In the next section the effects of the different types of abortion services on the abortion rate are explored.

DIFFERENT PROVIDERS AND ABORTION RATES

Table 7.3 presents the correlations among the provider specific provider rates, the provider specific abortion rates, and the total 1982 provider rate and abortion rate. Table 7.4 shows the correlations among the independent variables, the provider specific abortion rate and the total 1982 abortion rate. The effects of the different types of providers on the abortion rate are examined by regressing the specific types of providers on the abortion rate for the corresponding type of provider in three separate equations. The standardized beta coefficients for the three equations are presented in Table 7.5. The interest in this part of the analysis is in the effects the different providers have on the abortion rate.

TABLE 7.3 Intercorrelations of Three Provider Specific Provider Rates, Total Provider Rate, Three Provider Specific Abortion Rates, and Total Abortion Rate, 1982.

	2	3	4	5	6	7	8
1. Abortion Rate	.48	-.17	-.18	.47	.40	.48	.34
2. Hospital Abortion Rate		-.63	.10	.34	.40	-.12	.25
3. Large Non-Hospital Abortion Rate			-.82	-.65	-.52	.16	-.65
4. Small Non-Hospital Abortion Rate				.52	.32	-.18	.59
5. Provider Rate					.78	.33	.90
6. Hospital Providers						.15	.46
7. Large Non-Hospital Providers							.23
8. Small Non-Hospital Providers							

TABLE 7.4 Correlations of Measures of Abortion Issue with Three Provider Specific Abortion Rates, and Total Abortion Rate, 1982.

	Hospitals	Large Non-Hospitals	Small Non-Hospitals	Abortion Rate
Anti-Abortion Movement	-.18	.12	-.11	.21
Pro-Abortion Movement	-.19	.26	-.21	.10
Religious Orientation	-.07	.32	-.43	.16
Families	-.08	-.32	.42	-.30
Divorce	-.19	-.15	.28	.13
Status of Women Index	.30	-.41	.32	.18
Restrictiveness Index	-.33	.24	-.08	-.21
Physicians	.47	-.06	-.29	.72
Metropolitan	.36	.26	-.58	.72
Black	-.08	.44	-.44	.16
Unmarried	.32	.29	-.57	.62
Education	.25	-.51	.42	.26
Females	.27	-.33	.21	.40

TABLE 7.5 Standardized Regression Coefficients for Measures of Abortion Issue on Three Provider Specific Abortion Rates, 1982.

	Hospitals	Large Non-Hospital	Small Non-Hospital
Anti-Abortion Movement	-0.28**	-0.12	0.08
Pro-Abortion Movement	-0.05	-0.01	0.07
Religous Orientation	-0.09	-0.03	-0.01
Families	-0.09	0.16	-0.11
Divorce	-0.35**	-0.13	-0.03
Status of Women Index	0.14	-0.14	0.02
Restrictiveness Index	-0.22*	0.22*	0.08
Physicians	-0.03	-0.31	0.27*
Metropolitan	0.37*	0.43**	-0.59**
Black	-0.06	0.01	0.04
Unmarried	0.03	0.13	-0.46**
Education	-0.03	-0.34*	0.13
Females	0.12	-0.28*	0.21*
Provider	0.27*	0.34*	0.36**
Adjusted R^2	0.34	0.33	0.63

* Value greater than standard error
** Value greater than twice the standard error

Results

It appears that by looking at the effect of specific types of providers on their corresponding abortion rate leads to a different picture of the interrelationship among the various dimensions of the abortion issue, availability of provider, and utilization of providers depending on the type of provider. The bottom row of Table 7.5 reveals the extent to which the predictor variables successfully accounted for the differences in the abortion rates. The adjusted R-squares are much lower than the equations estimating the 1982 abortion rate. Together, the variables were better predictors of the abortion rate in small non-hospital facilities than the other provider specific abortion rates.

The effects of several variables shifted direction depending on the type of provider, such as the restrictiveness index, percent metropolitan and proportion females age 15-44. Two variables which were important determinants of the 1982 abortion rate showed weak effects on all three models: percent black and family presence. Three variables that had minor effects on the total abortion rate showed similar relationship to the provider specific abortion rates: the religious orientation index, status of women index and pro-abortion social movement activity. As one would expect, each specific provider rate was an important determinant of its corresponding abortion rate.

Several variables reflecting public sentiment and values have negative effects on the hospital abortion rate, such as values regarding nontraditional views of the family, a climate of regulations

against abortion and harassment by anti-abortion activists. Together, these measures lend support to the belief that hospitals tend to be more easily influenced by community norms and public opinion. The strongest determinants of the large non-hospital abortion rate are the restrictiveness index, percent metropolitan, two characteristics of high demand populations - education and proportion females 15-44, and the large non-hospital provider rate. The small non-hospital abortion rate responded to somewhat different variables, such as the physician rate, percent metropolitan, proportion females of reproductive age, and the small non-hospital provider rate.

Anti-abortion movement activity has a strong negative effect on hospital abortion rates, and weak effects on non-hospital abortion rates. Except for the divorce rate, the other measures of lifestyle differences show minor effects on the abortion rates. The restrictiveness index has a negative effect on the hospital abortion rate, and a positive effect on the large non-hospital abortion rate. It is worth noting that in Chapter 6, the effect of the restrictiveness index was limited to the 1982 provider rate. In the analyses of the different types of providers, the restrictiveness index has exhibited diverse effects depending on the availability and utilization of the different facilities.

The physician rate and percent metropolitan did not show strong effects on the specific abortion rates as they did with the total abortion rate for 1976 and 1982. The results indicate that when the effects if the specific types of abortion facilities are examined, the impelling effect of the characteristics associated with the existence

of health care services breaks down. The physician rate had a strong effect on the small non-hospital abortion rate. This connection is easy to understand given that facilities performing less than 400 abortion per year tend to be physicians' offices. Percent metropolitan had a positive effect on hospital and large non-hospital abortion rates, and a negative influence on the abortion rate in small non-hospital facilities. Population characteristics are important factors in the abortion rate models for non-hospital facilities only. Both education and proportion females age 15-44 have negative effects on the abortion rate in large facilities. The abortion rate in small non-hospital facilities responded to marital status and proportion females of reproductive age in the population. In contrast to the negative effect of the proportion of females 15-44 on the large non-hospital abortion rate, this variable has a positive effect on the abortion rate in small non-hospital facilities. The proportion of females of childbearing ages shows a positive effect on both the 1976 and 1982 abortion rate. The interpretation given was that the finding expressed the direct relationship between the population who have a high demand for abortion services and actually use the service. The different effects of this variable on large versus small non-hospital settings suggest that finer age categories are needed to understand which groups of women of reproductive age obtain abortion services and in what types of facilities.

Similar to other abortion rate models, the availability of providers is certainly an important factor in the utilization rate. However, the specific provider rates are not the most powerful

determinants of their respective abortion rates. Comparing the beta coefficients in Table 7.5, it can be seen that for non-hospital abortion rates percent metropolitan and characteristics of the population, unmarried and education, have strong effects on the abortion rate. Hospital abortion rates are responsive to availability of hospital abortion services, as well as percent metropolitan, the divorce rate and anti-abortion movement activity. In general, non-hospital abortion rates are more responsive to characteristics of the population in demand of abortion care than the hospital abortion rate. The hospital abortion rate, on the other hand, is more responsive to public pressure as witnessed by the strong negative effects of the divorce rate and restrictiveness index.

CONCLUSIONS

The results of the exploratory analyses emphasize the differences among the types of providers. For both the specific provider rates and abortion rates, the patterns of relationships differed among the five components. Several variables which had weak effects on the 1982 provider rate and abortion rate became important determinants of the provider specific rates. For example, the restrictiveness index showed a negative relationship to the 1982 provider rate and had a minor effect on the 1982 abortion rate. Upon further examination, the restrictiveness index had an important influence on the provider rate and abortion rate depending on the type of facility. Characteristics

of the health care system also showed diverse effects when brokendown by type of facility. Most notably, the physician rate exhibits a dominant effect in small non-hospital facilities, and weak effects on the other types of abortion services.

The restrictiveness index and characteristics of the health care system are just two examples of how patterns of the political and social factors differ between the total rates and the provider specific rates. Some of the inconsistency may be accounted for by the need to disaggregate some of the indicators of the health care system into more conceptually meaningful measures. It is clear from the results that the extent to which the social and political conditions and the health care system differentially effect the various abortion services need to be studied further. Differences among the bivariate relationships of the various factors and the provider specific rates provide the statistical reasoning for future research on the different types of abortion facilities.

Research is warranted beyond the statistical reasons just given. It is quite obvious from this study that the types of abortion facilities are sufficiently different from one another. Historically, the providers have been responding to different needs for abortion services. Yet, research on abortion services tends to mask the effects of these differences by looking at the total provider rate and abortion rate. This exploratory analysis is a step in that direction. In the concluding chapter, the implications of the research findings on abortion services are discussed.

Chapter 8

ABORTION, ABORTION SERVICES AND POLICY IMPLEMENTATION

Abortion continues to be an emotionally charged issue which elicits diverse reactions. This study examined five factors predicted to be related to abortion, and assessed their influence on the availability and use of abortion services. A policy implementation framework was used to explore, conceptualize and analyze the extent to which these factors may have important effects on abortion services. Availability and use of abortion services were viewed as measures of the implementation of the 1973 Supreme Court rulings on abortion. This study, then, was an investigation and interpretation of the factors which affect the implementation of abortion policy.

This chapter is divided into four sections. The purpose of the first section is to review the implementation model developed in Chapters 2 and 3. A review of the research findings is presented in the second section. In the third section policy recommendations based on the research findings are presented. The discussion and policy recommendations are based on the findings that were statistically significant in both the 1976 and 1982 models of abortion services, including social movement activity. The fourth section discusses contributions of this research to the field of sociology and to the area of policy analysis.

IMPLEMENTATION MODEL OF ABORTION POLICY

This study demonstrated that many factors associated with the current abortion issue work together to shape the course of abortion policy implementation. In Chapter 2, traditional implementation theories were reviewed and attention was given to the growing recognition of the broader environment in which implementation takes place. This research differs from most implementation studies by taking into account the social context surrounding abortion policy. Based on social theorists Merton (1968) and Gusfield (1981), the ideas of foreseen and unforeseen consequences were developed and used as a means to distinguish the various meanings of and reactions to abortion since the 1973 Supreme Court decision. In Chapter 3, five factors thought to be related to abortion policy implementation were developed: the presence of pro- and anti-abortion movements in the political conflict over abortion, lifestyle differences between abortion opponents and supporters, the feminist struggle for reproductive rights for women, the attempts to control abortion through restrictions, and the role of the health care system in terms of characteristics of the system and the demand for care. These components reflect different aspects of the current abortion issue.

Based on traditional implementation research, foreseen consequences refer to specific actions by those organizations or political systems directly involved in the implementation of the policy. In this research, two factors are associated with foreseen consequences: legislative efforts to overturn the judicial rulings and the role of

the health care system in relation to availability of abortion services. In contrast, investigation of unforeseen consequences looks beyond the boundaries of associated organizations to other areas which may be influenced by changes in abortion policy and, in turn, affect the availability of abortion services, such as pressures by groups whose values differ, existing gender relations, and the activities of social movements.

FACTORS AFFECTING ABORTION SERVICES

The results showed that the provider rate and abortion rate are conceptually distinct measures of policy implementation in that they are not consistently related to the same explanatory factors. The results for the provider rate measure showed important effects of anti-abortion activity, high divorce rate, increased status of women relative to men, high physician rate and low urbanization. High abortion rates were found in states with active anti-abortion movements, fewer families with their own children, high physician rate, high urbanization, large black population, high proportion of women age 15-44, and a high provider rate. Since the divorce rate and the status of women index are more consistently related to the provider rate than to the abortion rate, it is suggested that the provider rate responds more to the social and political climate than does the abortion rate. The abortion rate is affected by the social and political climate through the negative influence of family

presence and the availability of services. In addition, the abortion rate is clearly affected by characteristics of the health care system which provides the service and by the level of demand for abortion. In this respect, abortion is similar to other health services.

Both the availability and utilization of abortion services are strongly affected by characteristics associated with the existence of health care facilities, such as metropolitanism and availability of physicians. Percent metropolitan showed a consistent negative influence on the provider rate, thus indicating that more services are available in states with fewer metropolitan areas. One interpretation given discussed the efficiency of service delivery relative to population size; in urban states populations are more concentrated and can be served by a smaller number of providers.

As long as abortion requires the use of health care facilities, abortion will remain within the domain of the health care system. The strong effects of the variables percent metropolitan and physician rate for the availability of services indicates that abortion services share many of the problems associated with the availability of other health care services. In addition, the findings also demonstrated that anti-abortion activity was an important factor affecting abortion services. The extent to which social movement activities affect the provision of other health care services has yet to be determined. But, unlike other health care services, abortion providers are harassed for providing services that are legal. Abortion services share may of the problems associated with the provision of health care services, and are different from other health care services in that

the issue of abortion itself sparks debates and reflects deep differences in moral and social values. Several empirical investigations have shown that the uneven abortion rate is primarily due to the gap in geographic availability of abortion services. Since 1973, studies have consistently tracked the unavailability of services and estimated how much of the need for abortion services was met. The purpose of these estimates was to identify the locations where services were most lacking, and to help future plans for the development of abortion services. The results from this study support the importance of the availability of abortion services in influencing the abortion rate. The findings showed that measures of the social and political climate, along with the role of the health care system, are important factors in determining whether abortion services are available or not, and whether they are used. Availability and use of abortion services occur within a context of differing values concerning the family, the economic position of women relative to men, and characteristics associated with the provision of health care services (physician rate and percent metropolitan). Examination of the special roles played by various factors are important, however, it is the interpretation of the interrelationship among the factors that tells the story about abortion services. The findings from this research suggest that in order to increase the number of abortion services, the social and political climate of a community must be assessed in conjunction with the limitations associated with the availability of health care services.

POLICY RECOMMENDATIONS

In this section two recommendations based on the research findings are given. These recommendations assume a goal of changing conditions and increasing the availability of abortion services. The first recommendation concerns social movement activities. The other recommendation is less grandiose in intention, and is based on observations from this study.

1) Increase the number of abortion providers. The divorce rate, status of women index, and the physician rate all had positive effects on the provider rate. This means that efforts to increase the availability of abortion services should concentrate on the social and political climate of women's lives, and the existing medical network. In Chapter 6, it was pointed out that pro-abortion movement activity appeared to be in response to anti-abortion movement activities. It is recommended that pro-abortion movements need to fight for changes in women's social and economic status relative to men, and to increase the availability of physicians in providing abortion services. These research findings support a feminist interpretation of reproductive rights which views the patterns of fertility control in relation to the social and economic conditions that structure women's lives. Consequently, mobilization of pro-abortion movements around issues which support different types of family structure and affect the rights of women socially and economically are crucial for the

availability of abortion services.

2) Keep abortion legal. This recommendation is based on two observations. First, the empirical findings from this research shows that the demand for abortion is separate from how readily services are available. The abortion rate is affected by the social and political climate primarily through the availability of abortion providers, along with the existing characteristics of the health care system, and with the level of demand for abortion. These findings indicate that the availability and use of abortion services are a function of the economic status of women, pressures by social movements and limitations associated with the health care system, and that making abortion illegal will not eliminate the need for abortion. Second, the trend data in Chapter 5 shows that abortion rate has continued to increase since 1973. Clearly, this finding demonstrates the continued reliance on abortion as one means of fertility control. It would be difficult to reverse this trend, especially without introducing changes in other methods of fertility control and changes in the conditions of women's lives. From a policy perspective, reversing the legal status of abortion will not eliminate the demand.

CONTRIBUTIONS TO SOCIOLOGY AND POLICY ANALYSIS

One contribution of this research is that it offers a different approach to the study of abortion and abortion services. This study

pulled together knowledge about abortion from empirical and nonempirical sources and placed the information within a policy implementation framework. The many responses to abortion, the elements associated with abortion services, and explanations of the current abortion debate were examined as potential factors influencing the availability of abortion services.

Empirical research on abortion and abortion services has tended to be atheoretical in the attempts to explain the differences in the abortion rate. Borders & Cutright (1979), Hansen (1980), Henshaw, Forrest, Blaine & Tietze (1982), and Henshaw, Forrest & Blaine (1984) have all shown a variety of demographic, political and socioeconomic factors to explain differences in the abortion rate and changes in the abortion rate. They all arrived at a similar conclusion: increasing the number of providers so that all women who need and want them will be able to obtain the service. These studies have ignored the influence of factors such as the social position of women relative to men, political pressure against abortion and availability of physicians in determining whether services are available and used.

Theoretical approaches and insights to abortion have generally been limited to specific aspects of the debate, such as Luker's (1984) account of West Coast activists on both sides of the abortion issue, Merton's (1981) observation of one faction of the Right-to-life Movement, and Staggenburg's (1987) look at the growth of the National Abortion Rights Action League (NARAL) in Illinois. Petchesky (1984) went beyond the analysis of social movements, and placed the moral issue of abortion in a social and historical context with a focus on

the viewpoint and experience of women for whom abortion has the greatest significance.

Separately, none of the empirical studies or the theoretical approaches helped answer practical questions about the effects of the Supreme Court decision on the availability of abortion services. Together, the various approaches helped to see that even if the health care system completely accepted the provision of services, there still is a belief system strong enough to affect the availability and use of abortion services. Legalization has paved the road for the material conditions to be met, however changes in values and beliefs are needed in order for the material conditions to be realized for all women. One strength of this study lies in the interweaving of different approaches, such as moral, feminist, and social movements, to the study of abortion in order to present a more comprehensive context of the abortion issue in relation to the actual availability of abortion services.

A second contribution is to the field of sociology; and more specifically, in supporting and extending the theoretical work of Gusfield (1963) in symbolic politics. Gusfield's (1963) work on the Temperance Movement was built on Weber's observation that groups are not necessarily linked to formal class positions. Gusfield (1963) showed how deeply held values can distinguish one subculture from another, and how issues of moral reform are means by which culture groups preserve their position in society. Within Gusfield's (1963) framework, political acts can be viewed as symbolic acts. The status of a political act reflects the position of different groups. The

issue takes on importance for what it represents about a lifestyle or cultural values being recognized or derogated. Gusfield's (1963) work is important for pointing out that differences between deeply held values can be used to distinguish lifestyles between groups, and that the conflict between groups can be dynamic enough to eventually culminate in the passage of political acts.

This research used Gusfield's (1963) framework for differentiating groups on the basis of strongly held values - fundamental orientation to the world, with a traditional view of the family versus a secular world orientation, and a view of the family as a changing social institution. Gusfield (1963) investigated how clashes between subcultures lead to the creation of certain political acts. This study, instead, focused on the differences as responses to a given act and questioned the consequences of these disagreements for the availability of services. Using the language of a policy analyst, Gusfield (1963) focused on policy development, whereas this study concentrated on policy implementation. The results support the theoretical position that the pressure of groups bound by shared value orientations can be strong enough to effect social change, whether it be in the passage of an act or the enactment of a given policy. Furthermore, the findings showed that policies have symbolic meaning which can give rise to pressures and effect policy outcomes.

Third, this study intended to contribute to our understanding of the dynamics between social movement and social policy, and possibly suggest theoretical links between the two. Specifically, the question addressed was how social movements affect policy implementation. This

research fell somewhat short of the goal, since this question was not able to be answered. Measures of pro- and anti-abortion movement activity on a state level were more difficult to obtain than expected. Use of NewsBank Index as a source was a creative approach for assessing social movement activity, but it was also less than adequate. NewsBank indexes newspaper articles in a limited number of cities. Therefore, this measure was biased in favor of cities of a particular size. The articles did provide salient insight about the two movements, although other resources may provide more representative information about social movement activity. Based on the content analysis of the articles, pro-abortion movement activities were most often in response to anti-abortion activities.

Another shortcoming to the use of social movement measures in this study has to do with methodological considerations and answering the question whether social movement activity affects availability of abortion services. As suggested in Chapter 6, in order to test whether social movement activity has affected the provision of services a design is needed that can assess before and after effects of social movements activity, or a time series design in which observation over time would provide some answers. Perhaps by pointing out the unexpected shortcomings in measuring social movements, future research and measurement of social movement activity will be enhanced.

The fourth and final contribution of this study is to the general field of policy analysis, and to the specific study of policy implementation. Most significantly, this research extended the scope of implementation research from programmatic goals and concerns to an

approach which accounts for the general social and political culture surrounding a policy.

The study of the policy making process is difficult. It is a complex subject on which it is difficult to impose order (Smith 1975). Because of its empirical difficulties, the study of policy is usually limited to the actors and actions involved in making government decisions or enacting them, and considering the relationships of policy outputs to socioeconomic conditions, party competition, etc. Use of this limited approach to abortion policy would have focused on availability of abortion services as a response to demand for services from those populations in need, and as limited by regulations against abortion. Yet, the results from this study showed that other factors are important.The findings from this study suggest that traditional policy analysis and implementation theory are limited for evaluating policies. Policies affect populations that they are designed to serve as well as non-partisans, and they are based on an accumulation of values and normative standards.

The meaning a policy attains is often created by the responses to it. Using this interpretive approach to policy, it seems logical to inquire how various meanings and understandings in turn feedback to shape the implementation of a policy. Societal values as expressed through reactions to policies can be seen to influence implementation. In essence, this study expanded the traditional meaning of policy from a mandated decision to include a judicial right, and took an approach to implementation which accounted for the general culture surrounding a policy. In the case of abortion policy, the controversy surrounding

the issue since 1973 is seen as its general culture: cultural values, social conditions of women's lives, political pressures, and limitations of the health care system. Together, these components weave a more comprehensive and complex understanding of abortion services.

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APPENDIXES

APPENDIX A

DATA SOURCES

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Total Providers, 1976, 1977, 1978

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Total Physicians, Non-Federal, 1980
Divorce Rate, 1980

Bureau of Census. 1983. 1980 Census of Population, vol. 1, Chapter B, General Population Characteristics, Part 1, United States Summary Puplication pcb80-1-b1. Washington, D.C.: Bureau of the Census.

Female Population ages 15-44, 1980

Bureau of Census, 1983. 1980 Census of Population, Voll, Chapter C, General Social and Economic Characteristics. Washington, D.C.: U.S. Government Printing Office.

Persons 25+ Years: Median School Years Completed, 1980

Bureau of Census. 1982. Provisional Estimates of Social, Economic, and Housing Characteristics, 1980. Census of Population and Housing Document #PHC80-S1-1. Washington, D.C.: U.S. Government Printing Office.

Percent Families with own Children <18 years, 1980.
Percent Females, 15+ years: Now Married

Bureau of Census. 1982. State and Metropolitan Data Book, 1982. Washington, D.C.: U.S. Department of Commerce.

Percent Metropolitan, 1980
Percent Black Population, 1980
Family Households: Total, 1K, 1980
Family Households: Number of Female Headed, 1K, 1980
Number of Families Below Poverty Level, 1K, 1980
Number of Female Headed Families Below Poverty, 1K, 1979

Bureau of Census. 1980. Census of Population, Vol. 1: General and Social Economic Characteristics. Washington, D.C.: U.S. Government Printing Office.

Males 15+ Years: Full-Time Workers Median Income, 1979
Females 15+ Years: Full-Time Workers Median Income, 1979

Bureau of Census. 1979. State and Metropolitan Area Data Book, 1979. Washington, D.C.: U.S. Department of Commerce

Divorce Rate, 1976

Bureau of Census. 1978. Statistical Abstract of the U.S.

Percent Metroplitan, 1976

Bureau of Census. 1977. Statistical Abstract of the U.S.

Population, per 1,000 1976

Bureau of Labor Statistics. 1982. Geographic Profile of Employment and Unemployment. Section II. Estimates for States. Washington, D.C.: U.S. Government Printing Office (Bulletin 2170).

Number in Male Civilian Labor Force, 16+ years, 1982
Percent Male Population in Civilian Labor Force, 16+ years, 1982
Number of Males Employed, 16+ years, 1982
Number in Female Civilian Labor Force, 16+ years, 1982
Percent Female Population in Civilian Labor Force, 16+ years, 1982
Number of Females Employed, 16+ years, 1982

Bureau of Labor Statistics. 1978. Work Experience and Earnings in 1975 by State and Area. Survey of Income and Education, Spring 1976 Report #536. Washington, D.C.: U.S. Department of Labor.

Males 17+ Years: Full-Time Workers Median Income, 1975
Females 17+ Years: Full-Time Workers Median Income, 1975

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Persons 18+ Yrs: Median School Years Completed, 1976
Civilian Labor Force: % Male Population 16+ Years, 1976
Civilan Labor Force: % Female Population 16+ Years, 1976
Percent Families with own Children < 18 years, 1976
Percent Black Population, 1976
Female Population, age 15-44, 1976
Unemployed: Percent Male Civilian Labor Force, 1976
Unemployed: Percent Female Civilian Labor Force, 1976
Percent Families Below Poverty Level, 1976

Percent Families Below Poverty Level, Female Headed, 1976

Forrest, Jacqueline D., Ellen Sullivan and Christopher Tietze. 1979. Abortion 1976-1977 Need and Services in the United States. NY: The Alan Gutmmacher Institute.

Abortion Rate, 1973, 1974, 1975, 1976

Forrest, Jacqueline D., Ellen Sullivan and Christopher Tietze. 1989. "Abortion in the U.S., 1978-1979." Family Planning Perspectives 11(6):329-341.

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Abortion Providers, 1979, 1980

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Abortion Providers, 1981, 1982
Abortion Rate, 1979, 1980, 1981
Provider Specific Provider Rates, 1982
Provider Specific Abortion Rates, 1982

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Abortion Rate, 1978.

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Abortion Rate, 1982.

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Percent Catholic, 1976

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Marital Status: Females Age 14+, Percent Married, 1976

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Percent Southern Baptist Convention, 1971

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Percent Catholic, 1980
Percent Southern Baptist Convention, 1980

APPENDIX B

RESTRICTIVENESS INDEX

Johnson, Charles and Jon Bond. 1980. "Coercive and Noncoercive Deterrence Policies." Law and Policy Quarterly 2(1):106-128.

1. Performance by licensed physicians required (first trimester)
2. Facility requirements (first trimester)
3. Facility reqiqrements (after first trimester)
4. Abortion prohibited except to save woman's life or health (after viability)
5. Consultation or certification by other physician(s) required (after viability)
6. Woman must be informed of consequences of or alternative to abortion or availability of counseling
7. Spousal consent required
8. Parental consent required if unmarried minor
9. Physician required to report all abortions to state health agency
10. Advertising abortion services prohibited
11. Using public funds for abortion except for life or health reasons prohibited
12. Nonperformance by institution authorized
13. Nonperformance by individuals authorized
14. Relieves liability and prohibits discriminatory, disciplinary or recriminatory action against those refusing to participate in abortions (institutions)
15. Relieves liability and prohibits discriminatory, disciplinary or recriminatory action against those refusing to participate in abortions (individuals)

16. Measures to save viable fetus required

17. Live-born aborted child made public ward