

RU 486 and Abortion Practices in Europe: From Legalization to Access

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When the Food and Drug Administration licensed RU 486 (Mifepristone) for medical use in the United States late last year, most European women already had access to the “abortion pill”: In three European Union countries it had been available for almost a decade. France, where RU 486 was first developed and manufactured, approved its use in abortion clinics in 1988 but delayed distribution until 1990. Legalization in Britain came in 1991, followed by Sweden a year later. More recently, in July 1999, the European Medicine Agency announced that the drug had been registered for distribution in Germany, Austria, Belgium, Denmark, Spain, Finland, Greece, and the Netherlands.

RU 486, whose commercial name in Europe is Mifegyne, has long been at the center of an impassioned battle over reproductive choices both in Europe and in the United States. A key reason for this is that for women in the early stages of pregnancy it is a low risk, highly effective abortifacient with demonstrated advantages over surgical abortion procedures. Not only is it a safe, noninvasive option for women who need to end their pregnancies but it also allows a woman greater autonomy and control throughout the abortion process. Based on their observations during clinical trials, some medical practitioners in the United States predict that if it were widely available, medical

abortion using RU 486 could “change abortion practice in the United States,”¹ a prospect that galvanizes pro-life opposition groups. Whatever their position on abortion rights, many analysts are concerned that making abortion simpler, easier and more accessible will also make it more difficult to regulate and will encourage women to choose this option when faced with an accidental or problematic pregnancy. The result, they fear, will be higher abortion rates.

The central question addressed in this paper is whether European experience supports these predictions. Have abortion rates and practices actually changed in Europe over the decade since French authorities opened the door to medically-induced abortion? Of particular interest are national variations in the use of medical over surgical abortion procedures: Why is Mifegyne used in one-third of the abortions performed in France and Sweden, while in Britain it is underused and in Germany demand for the drug has been so low that it is no longer being distributed? We consider these questions, first, by taking a European perspective, then by moving to a more detailed comparison of German and French experiences.

Abortion Rates and Practices in Europe

One of the most striking conclusions to be drawn from cross-national data is that abortion rates have dropped or remained stable in most western European countries where Mifegyne is legal. The second conclusion, drawn from interviews with clinic patients, is that many women who have a choice prefer Mifegyne-induced terminations over surgery (usually vacuum aspiration or, in some cases, dilation and curettage). Yet access to medical termination varies widely, both across and within countries. Even in

¹ Charlotte Ellertson, Wendy Simonds, Beverly Winikoff, Kimberly Springer, and Debjani Bagchi, “Providing Mifepristone-misoprostol medical abortion: the view from the clinic,” *Journal of the American*

France and Britain, where Mifegyne has been legal for years and where health care is publicly funded, wide regional variations in availability are evident. Because physicians may choose for economic reasons not to offer medical abortions, availability also varies from clinic to clinic in many countries. Depending on how health care is funded, access to Mifegyne may vary as well with a woman's income and social class. A final and important limitation on access is the narrow window of opportunity available to women who would choose this form of abortion: Because it is most effective in the earliest stages of pregnancy, governments limit the use of Mifegyne to the first seven (France, Germany, United States) or at most nine weeks after the beginning of the last period (Britain, Sweden).

Researchers at the Alan Guttmacher Institute have collected governmental data that enable us to follow changes in abortion rates over time for many European countries. While it is too soon to know the impact of the wave of Mifegyne legalizations that occurred in 1999, we can look at evidence of change in the three countries where medical abortion has been legal since the early 1990s. Table 1 shows that in France and Sweden

| | 1986 | 1991 | 1996 |
|-----------------|------|------|-------|
| England & Wales | 13.5 | 15.2 | 15.6 |
| France | 13.9 | 13.6 | 12.4* |
| Sweden | 18.9 | 20.4 | 18.7 |

Medical Women's Association, v. 54, no. 2, Spring 1999: 91-96, 102 (electronic)

Table 1. Rates of legally induced abortion, 1986-1996²

the number of abortions per 1000 women declined between 1991 and 1996. The downward trend in France began before Mifegyne was introduced, as we see by tracking changes over the decade beginning in 1986. Sweden has a more cyclical pattern of peaks and troughs only hinted at in Table 1, but a look at the longer trend line since the mid-1970's suggests that legalizing Mifegyne has little impact on this cycle.³ For Britain, the story is more complex but also apparently unrelated to the introduction of the new abortion pill. Family planning experts attribute the upward trend we see in Table 1 to Britain's piecemeal approach to sex education and contraception.⁴ We can also discount the impact of Mifegyne here because medical abortions occur too rarely in Britain to make an impact on the country's abortion rate. It would appear, then, that legalizing early medical termination has not encouraged women to have abortions. In fact, the data in Table 1 suggest that in western Europe the opportunity to choose a medical abortion has no bearing on a woman's decision to end her pregnancy.

If legalizing Mifegyne has not made abortion more attractive in Europe, where abortion rates are the lowest in the world, it *has* affected the preferences of many abortion patients, who may now be given a choice between surgery and drug-induced termination. Over the past 12 years, 620,000 women have safely used Mifegyne as an

² Data is drawn from Stanley K. Henshaw, Susheela Singh, and Taylor Haas, "Recent Trends in Abortion Rates Worldwide," *Family Planning Perspectives*, v. 25, no. 1 (March 1999): 3-4. According to this article, the French government did not report data for 1996, so we have substituted (and marked with an asterisk) the 1995 rate.

³ For data since 1975 see *ibid.*

⁴ For more on Britain's abortion trends, see Sarah Lyall, "Britain Allows Over-the-Counter Sales of Morning After Pill," *New York Times*, January 15, 2001: A1.

early option for non-surgical abortion in Europe.⁵ Clinical trials have shown it to be as effective as older abortion procedures, with fewer side effects.⁶ These advantages have been widely publicized in the popular media. For example, a German woman's magazine, *Brigitte*, told its readers that the advantages of a "gentle abortion" with Mifegyne are considerable⁷: it is less stressful physically than surgical abortion, as the cervix does not need to be dilated. As a result, it is often less painful than vacuum aspiration, anesthesia is not required, and there is no risk of injury or infection. Future fertility is not affected. A woman may feel more in control and more self-directed than with other methods of abortion. Mifegyne is also used very early in gestation, thus reducing the time a woman has to live with an unwanted pregnancy.⁸ In *Elle*, a well

⁵ NARAL <http://www.naral.org./mediareources/fact/research.html>

⁶ Mifegyne works by blocking the receptor cells to which progesterone bonds in the uterine lining, making it impossible for progesterone to dock and prepare the lining to receive a fertilized egg. In order to enhance the effect of Mifegyne, an additional dosage of prostaglandin is given. This causes uterine contractions, which speed the sloughing off of the uterine lining. The method of combining Mifegyne with a prostaglandin is called Mifegyne +PG, and is the standard procedure used in European countries.

The regime is administered as follows: the pregnant woman takes three Mifegyne pills at the doctor's office and then returns home for two days. During this time period, Mifegyne atrophies the uterine lining that nourishes the embryo and thus kills it. The second stage of terminating a pregnancy with Mifegyne comes when the prostaglandin is administered, again at the doctor's office, on the third day. This time, the woman has to stay in the office, under medical supervision, for up to five hours. During this time, contractions start and the uterine lining, together with the embryonic tissue, is expelled, a process which can be accompanied by considerable cramping. In over 95% of all cases, RU 486 successfully terminates the pregnancy without additional surgical intervention. In approximately 5% of cases, an additional surgical abortion is required.

Once the uterine lining has been expelled, the woman returns home, but is required to come back for a check-up two weeks later. Via a vaginal sonogram, the physician ensures that the medical abortion has been complete. Thus, at least three doctor's visits are medically required to accompany a medical abortion with RU 486+PG.

⁷ <http://www.brigitte.de/gesundheit/frauen/verhuetung/mifegyne.html>.

⁸ While Mifegyne is quite safe, it is not a risk-free drug. Since it induces a process similar to a spontaneous miscarriage, it requires monitoring by health professionals before and during the abortion procedure. The prostaglandin administered in conjunction with Mifegyne frequently causes nausea, dizziness, a drop in blood pressure, painful cramping, and strong bleeding. (These symptoms have been reduced, however, under a new protocol that uses lower doses of Mifegyne followed by a synthetic prostaglandin, Misoprostol.) In France, a 31 year old patient (who happened to be a chain smoker) died in 1991 of prostaglandin-related causes. In order to minimize adverse outcomes, medical abortions are usually limited to women under 35 who have no history of asthma, heart, or kidney disease, who do not smoke, are not overweight and have no other known risk factors. For more detail on clinical results, see K. Holmgren,

known French women's magazine, women learned that "this pill will revolutionize women's lives, augment their power over their fertility, and....will permit them to abort more easily, even in the tranquillity of home."⁹

Many women are hearing these messages. The *British Journal of Obstetrics and Gynecology* reports that "almost 50% of abortion seekers in France prefer medical (drug induced) abortions." Studies in Aberdeen (Scotland) have shown that about 25% of women prefer a medical abortion, 25% prefer a surgical abortion and 50% have no preference.¹⁰ Reviewing twelve studies conducted in Sweden, England, Hong Kong, Scotland, Denmark, France and the United States, Beverly Winikoff finds that 60-70% of patients interviewed before their first-trimester abortions prefer Mifegyne to the surgical method. In re-interviews after their medical abortions, most patients believed they had chosen the right method, and in the eight studies which asked respondents whether they would choose a medical abortion again, 64-85% said they would.¹¹ Medical abortion is "not magic. It does not negate the act of ending a pregnancy. It doesn't make the act disappear"¹², but many women in the early stages of pregnancy prefer it as an alternative

"Women's Evaluation of Three Early Abortion Methods," *Acta Obstetrica et Gynecologica Scandinavica*, v. 71, no. 8 (December 1992): 616-23 (electronic).

⁹ Author's translation from material quoted in Jean Robinson, "Abortion Policy Debates and the Role of the SDF: Report to the SDF" (unpublished report to the Service de Droits de Femme, Government of France, no date): 30-31.

¹⁰ D.T. Baird, "Medical Abortion in Britain," *British Journal of Obstetrics and Gynecology*, v. 101, no. 5 (May 1994): 367-8 (electronic).

¹¹ Beverly Winikoff, "Acceptability of Medical Abortion in Early Pregnancy," *Family Planning Perspectives*, v. 27, no. 4 (July/August 1995): 142-148, 185 (electronic). For a similar endorsement based on a small study (100 patients) in Britain, see M.E. Maaita, C. Prasannan, J. Smith, E.J. Neale, "Women's Satisfaction With Medical Termination," *British Journal of Family Planning*, v. 25, no. 1 (April 1999): 9-11 (electronic).

¹² Suzanne Daley, "Europe Finds Abortion Pill Is No Magic Cure-All," *New York Times*, October 5, 2000: A3.

to surgery and value its contribution to their privacy and autonomy during the abortion process.¹³

As we might expect, the acceptance of Mifegyne as a means of non-surgical abortion varies from country to country in Europe, correlating directly to the legal alternatives and the support structures available in each country. For example, in France, where patients are required to stay in the hospital for three days for a surgical abortion, Mifegyne provides an attractive alternative administered on an out-patient basis. In addition, the procedure is fully covered by national health insurance. Under these conditions, there has been a slow but steady increase in the incidence of medical abortion: About 35% of French abortion patients choose Mifegyne+PG over surgical methods.¹⁴ In Sweden, 30% of women who terminate their pregnancies make a similar choice.

In the Netherlands, on the other hand, Mifegyne is a rarely used alternative. The country has a highly effective infrastructure of excellent walk-in surgical abortion services. Abortion carries no stigma, and the costs are covered by national insurance, so for most Dutch women, surgical options trump medical procedures in their cost-benefit analysis. Two other countries, Germany and Britain, limit access to Mifegyne indirectly because their public health systems do not cover physicians' treatment or facilities costs. Germany, as we shall see in more detail later in this paper, no longer has a national distributor for the drug because Femagen, the German pharmaceutical company, has met only a quarter of its predicted sales.¹⁵

¹³ Winikoff, *op. cit.*

¹⁴ Deutsche Presse-Agentur, "German Company Ends Distribution of Controversial Abortion Drug" (October 17, 2000): 1 (electronic).

¹⁵ M2 Communications Ltd., *M2 Europharma*, October 23, 2000, 1 (available in Lexis Nexis).

In Britain, medical abortion is considered by family planning professionals to be a desirable but underused option in a country where teenage pregnancies and unwanted pregnancies are on the rise. Although RU 486 is available in private clinics and through hospitals of the National Health Service, it is used in only 10% of abortions.¹⁶ The Birth Control Trust held a symposium in 1993 to find out why and discovered that NHS hospitals (where most women are treated) had neither the facilities nor the incentive to create facilities needed for medical abortions. Women who have just been given a prostaglandin are required to stay in the clinic for half a day or more as they wait to miscarry, so psychological support (usually, provided by a nurse) and a reasonably comfortable waiting room are minimum requirements. Since these services do not earn “performance points” under NHS guidelines, clinics have little reason to introduce them. Physicians from the Leeds Royal College of Obstetrics estimated that demand for medical abortion services from their clinic was very high, yet inadequate facilities forced them to limit the number of medical abortions to two a week.¹⁷ Another study published a year after the Birth Control Trust symposium listed two more disincentives for potential providers of drug-induced abortions: the special licenses required for clinics offering these services and the high purchasing price of Mifegyne and associated prostaglandins.¹⁸ For medical providers, then, the cost of drugs and services associated with the Mifegyne+PG procedure renders surgical abortions more economic. In an NHS strapped for money the cost of medical abortions exacerbates an underlying budgetary dilemma: “If women live in an area where a lot of abortions are requested and the budget is tight,

¹⁶ Baird, *op. cit.*

¹⁷ A. Furedi, “Clinical Experiences With the Abortion Pill (RU 486) in Britain,” *Pro Familia Magazin*, 5 (September-October 1993): 29-30 (electronic).

¹⁸ Baird, *op. cit.*

then they are often subjected to restrictions beyond those imposed by law.” This is part of a budget squeeze that is restricting access to any kind of abortion for certain women (those past 12 weeks pregnant) in many parts of the country, “despite the fact that the legal limit is 24 weeks.”¹⁹ What is happening in Britain, then, is that unless a woman has private health insurance or can pay out of pocket she may confront NHS-imposed limits on her abortion choices.

The most obvious conclusion to be drawn from these comparisons is that legalization of medical abortion is a necessary but far from sufficient step in broadening women’s access to abortion services. In some European countries, notably France and Sweden, abortion practices have changed in the current decade to incorporate non-surgical alternatives, but in other countries traditional practices remain in place. For women in the Netherlands, this may not be a bad thing in view of the broad access to abortion its health system provides. Women in Germany and Britain, however, have limited access to Mifegyne+PG despite the fact that both governments have licensed its use in public and private clinics. **Economic disincentives**—the high cost to clinics of medical abortion drugs and the low payment rates set by health ministries for medical abortion providers—are part of the explanation for access problems in both countries. Also at work are **professional decisions** made by physicians, especially physicians in private practice, who have been slower than their peers in public sector medicine to embrace the new medical alternative. This is not just an issue in countries with low use of Mifegyne+PG. In France, for example, private practitioners say they prefer surgical abortions because surgery is more convenient than the time consuming process involved

¹⁹ BBC News, May 19, 1998 from http://news6.thdo.bbc.co.uk/hi/english/health/latest_news/newsid_96000/96981.stm

in a drug-induced abortion.²⁰ The **organization of medical services** may influence a patient's evaluation of medical versus surgical options, as happens in France when women weigh a three-day hospital stay against the more appealing outpatient routine for a medical abortion. Finally, **bureaucratic accounting rules** such as NHS performance points also shape medical providers' incentives to offer (or not to offer) new abortion services.

So far, we have paid little attention in this analysis to the political framework within which economic, medical, and bureaucratic choices affecting access to RU 486 have been made, yet these choices are a direct outgrowth of governmental laws and policies regulating health and women's rights. Governmental power to shape access to reproductive choices can be seen in the case of France, where a strong minister of health overruled opponents of RU 486 and made legalization stick by establishing Mifegyne as "the moral property of women." Germany, the counterexample, enacted a weak abortion law in 1995, which denied public funding for most abortions and offered few incentives to physicians who may wish to provide medical terminations. As we shall see in these cases, governmental support is a crucial variable in successful efforts to make Mifegyne both legal and accessible.

The Politics of RU 486 in France

In France, as in the United States and Germany, abortion is a hot button issue that mobilizes a panoply of groups for and against liberalization of abortion laws. The debate to legalize abortion in 1975 (*La Loi Veil*) and to reaffirm its legality in 1979 (*La Loi Pelletier*) galvanized feminist groups such as the Mouvement de Liberation des Femmes

²⁰ Daley, *op.cit.*

(MLF), which organized in favor of abortion reform from 1970 on.²¹ MLF rose to national prominence in 1971 when it organized a signature list of 343 prominent women who admitted they had had illegal abortions. The opening round by MLF and the “343 *salopes* (sluts)” heightened public debate over French abortion policy, a debate conducted not only in the media (e.g. a petition published in 1973 by 331 doctors who had performed illegal abortions), but in the courts (e.g. the Bobigny trial of 1972 in which a young woman who had had an abortion was tried for criminal activity under French law). Formation of other groups--notably the MFPP (Mouvement Francais pour le Planning Familial), the MLAC (Mouvement pour la Liberte de l’Avortement et pour la Contraception), and *Choisir*-- provided leadership for an emerging social movement committed to an agenda of promoting women’s health and reproductive rights, including abortion reform.²²

These liberal, family planning and feminist groups soon encountered countermobilization by what has become a strong French anti-abortion movement, including dozens of groups, many of which benefit from support by the Catholic Church.²³ La Treve de Dieu (Truce of God), Laissez-les-Vivre (Let Them Live), and APF (Association Pour la Promotion de la Famille) all have ties to Catholic organizations. Some (for example, Treve de Dieu) have cross-border links with pro-life organizations in the United States. Others (for example, Laissez-les-Vivre) build alliances with the anti-immigrant, pro-natalist National Front. Anti-abortion activism by these groups takes many forms. Doctors and nurses who belong to (or sympathize with)

²¹ The authors would like to thank Jean Robinson for providing invaluable information on abortion politics in France. Our analysis in this section draws heavily on material from her unpublished report, *op. cit.*

²² *Ibid.*, 3-4.

²³ *Ibid.*, 6-7.

pro-life associations may refuse to do surgical abortions or to dispense drugs required for medical abortions.²⁴ A pro-life group called *Commandos anti-l'IVG* (Commandos Against Abortion), borrowing the tools of Operation Rescue in the United States, has blocked abortion clinics and harassed their employees and patients. (As in the United States, new laws against harassment curb these activities.) Most of these groups do not use the language of rights (women's rights, fetal rights) in arguing their case, but focus instead on preserving a traditionalist ideology of motherhood.

There is no doubt that abortion in France is a deeply salient, controversial, even polarizing issue. As Jean Robinson makes clear in her review of four abortion-related policy decisions, abortion brings “the Catholic Church, the medical profession, ethicists, lawyers, women of all classes, and men into the public debate.”²⁵ In so doing, it puts great pressure on governments by confronting them with very difficult political choices. This highly charged political context did not, however, prevent the French legislature (*Assemblée Nationale*) from enacting more liberal abortion laws in 1975 and 1979.²⁶ Neither did it stall, although it certainly slowed, efforts by the Ministry of Health to make RU 486 available to women who want early medical abortions.

When in 1988 the French government became the first to approve Mifegyne for use by physicians in medical abortions, it made a highly controversial decision. The drug was developed by Roussel-Uclaf, a French company in which the state held 36.25% ownership. RU 486 had been heralded by the liberal press, feminist and family planning

²⁴ Catholic doctors opposed to abortion have an international support network and their own website: http://www.Catholicdoctors.org.uk/CMQ/FEB_00/mifegyne.htm

²⁵ *Ibid.*, 8.

²⁶ Current French law permits abortion “on demand” in the first trimester as long as the procedure takes place in a licensed hospital or clinic. This places France among those (mainly industrialized) countries with the most liberal abortion laws. Anika Rahman, Laura Katzive and Stanley K. Henshaw, “A Global Review

organizations as “the next revolution in reproductive choice” and condemned by anti-abortion forces as “the pill of death.”²⁷ A month after the government issued its approval, anti-abortion harassment and threats against Roussel-Uclaf and its German parent company (Hoechst AG) led Roussel directors to suspend distribution of RU 486. Several months before this decision, anti-abortion demonstrators had invaded the company’s stockholders meeting, invoking the legacy of Nazism with comments like “You are turning the womb into a crematory oven.”²⁸ Activists also threatened a consumer boycott of all R-U pharmaceuticals. (Consumer boycotts in Britain, Spain, Germany and the United States ultimately pushed Hoechst AG, the owner of patent rights to RU 486, to transfer the rights to Exelgyn, a private company owned by one of the drug’s inventors.²⁹)

From a vantage point in Germany or the United States, the French government’s response to Roussel’s decision is remarkable. Two days after the company announced it would not distribute RU 486 in France, the Minister of Health called a Roussel vice president into his office to tell him that the government was ordering the company to resume distribution. The minister (Claude Evin) had the law on his side (he could transfer Roussel’s license for Mifegyne to another company willing to distribute the drug), and his decision carried low political costs for the Socialist government. Nonetheless, Evin’s justification for state intervention is still cited as a striking

of Laws on Induced Abortion, 1985-1997” (New York: Center for Reproductive Law and Policy, June 1998).

²⁷ *Op.cit.*, 29.

²⁸ *Ibid.*, 33. The link to Nazism invoked Hoechst’s pedigree as the successor company to I.G. Farben, maker of Zyklon B, the poison gas used in Nazi crematoriums.

²⁹ “Abortion Pill to be Available in Canada,” *The Gazette (Montreal)*, July 18, 1999: A4 (electronic).

endorsement of reproductive rights. In the interest of the public health, he said, “I must react.....the abortion pill has become...morally the property of women.”³⁰

It took about two years for the Conseil d’Etat (Council of State) to issue final rulings, which upheld the Ministry of Health’s decision and permitted Roussel to make RU 486 available to physicians in hospitals and clinics. Linked as it is to broader disagreements over abortion in French society, the controversy over RU 486 remains, but decisive governmental action has muted its impact on the choices available to a woman in the early stages of an unwanted pregnancy. France’s centralized governmental institutions facilitate decisive action in general and, in the arena of health care, vest significant political and administrative power in the Ministry of Health. Once the Conseil d’Etat cleared the way, access to medical abortions using Mifegyne could be implemented almost as any other new medical technology—through France’s heavily regulated network of public and private physicians, hospitals, and clinics. The public health insurance system treats abortion like any other medical procedure, so a patient’s costs are almost fully (80%) covered; regulations governing physicians’ costs and compensation seem to provide adequate financial incentives for those who do medical abortions; and the organization of medical services facilitates the new technology by sparing women using Mifegyne the anesthesia and hospital stay required for a surgical abortion.

This is not to say that medical abortions are universally accessible to French women. A recent parliamentary report found that private clinics perform many fewer drug-induced abortions than public clinics do because physicians in private practice prefer the convenience of surgical abortions: they take less time to complete than the two

³⁰ Author’s translation of quotation reported in Robinson, *op.cit.*, 35.

or three day process required for Mifegyne, and they involve fewer return visits. Some physicians with strong pro-life values refuse to perform abortion in any form—even early medical abortions. But anecdotal evidence suggests that access to “the gentle abortion” has changed abortion practices in France, even under the seven-day waiting period imposed under French law. No longer are medical abortions the province only of well educated, middle class women. There are also signs that providers may tailor the abortion procedures they recommend to the circumstances and needs of their patients: a nurse in a large clinic in Paris, for example, guides younger patients toward surgery so that they can avoid the lengthy procedure and psychological stress of abortion by pill. A final sign of change in French practices is the fact that abortions are taking place slightly earlier in the first trimester of pregnancy, as more women find they can end their pregnancies weeks earlier than surgical techniques allow.³¹

The Politics of RU 486 in Germany

Germany, on the other hand, illustrates the fate of this new medical option when weak governmental support and strong economic disincentives discourage physicians and patients from choosing it. RU 486 was approved for use in Germany in July 1999, four years after a politically charged and protracted overhaul of the country’s abortion law finally reconciled the former East Germany’s practices with those of the West.

Motivated by the legal dissonance created by German unification, the German parliament approved a new abortion law in 1992. It was intended as a compromise between the former German Democratic Republic’s liberal policy, which permitted abortion on demand within the first trimester, and the (West German) Federal Republic’s

³¹ Daley, *op.cit.*

more restrictive policy permitting abortion only in exceptional circumstances.³² After the reunification of Germany in October 1990, east and west Germans lived temporarily under different abortion laws, but the reunification agreement had specified a deadline by which the federal government had to propose a unified law for the whole country. The new law enacted in 1992 declared abortion up to the 12th week of pregnancy as legal, if a physician performed the procedure and if the pregnant woman had received appropriate counseling. But in May 1993, Germany's Federal Constitutional Court (*Bundesverfassungsgericht*) ruled the new law unconstitutional under Article 1 of the Basic Law.³³ The Court held that because the Basic Law (Germany's constitution) "protects the right to life of the unborn, even in opposition to its mother, abortion was to be regarded as generally unlawful. Recognition of women's constitutional rights, however, requires that abortions be performed in exceptional circumstances. Legislatures are empowered to stipulate the circumstances under which abortions may be regarded as reasonable."³⁴

This ruling highlighted a tension between two competing constitutional protections, the right to life of the unborn child and the right to dignity of the pregnant woman. It also framed Germany's current abortion law, adopted by the federal parliament in July 1995. The revised law does not run afoul of the Constitutional Court, because it reaffirms the principle that abortion is illegal. It also accords dignity to the

³² Exceptional circumstances included pregnancies that resulted from rape or incest, endangered the mother's life or health, or indicated irretrievable damage to the fetus. Legal abortions could also be performed in cases of social hardship, such as poverty or single parenthood. This social exception was often interpreted broadly, giving West German women greater access to legal abortion than the letter of the law might imply (Jutta Helm, personal communication, April 27, 2001).

³³ Article 1 reads: "The dignity of man is inviolable. To respect and protect it shall be the duty of all public authority." Quoted in The Center for Reproductive Law and Policy, *Women of the World: Formal Laws and Policies Affecting Their Reproductive Lives* (New York, August 1995): 21.

³⁴ *Ibid.*, 18.

pregnant woman, because it suspends legal prosecution for abortions performed for any reason within the first trimester of pregnancy—in effect, permitting abortion by request during this period. As under the old law, abortions are also legal during the first 22 weeks if the fetus is impaired or the pregnancy resulted from a criminal act. After the 22nd week of pregnancy an abortion may only be performed for medical reasons.

To say that the current law takes an ambivalent position on abortion is putting it mildly. The law stipulates, for example, that a woman must receive counseling from her doctor and from a second, independent source. Counseling must give priority to protecting both the “unborn child” *and* the woman’s right to choose and is widely interpreted as intended to dissuade women from choosing abortion. National health insurance, known in Germany as “sickness funds,” covers the cost of legal abortions (those stemming from rape, incest, life and health endangerment, fetal impairment or social hardship), but since abortions for other reasons are technically illegal, women who cannot claim one of these exceptions must pay for the procedure themselves.³⁵

This legal ambivalence toward abortion in Germany is the result of a compromise between principled opposition to abortion and the pragmatic acknowledgment that abortion cannot be legislated out of existence. Opposition to abortion is rooted in an ethical judgment that no one has the right to interfere with the unborn child’s right to life. This view is supported by the Christian Democratic Party and the Lutheran and Catholic Churches, both of which are strong social and political voices in German society. Opposition to abortion is further buttressed by a collective societal recoiling from making choices about life and death issues, largely as a historical reaction against Nazi eugenics policies. Many groups in Germany, on the other hand, do support liberal abortion laws: a

newly unified Germany absorbed an East German population that had grown up with a pragmatic and guilt-free view of abortion, since their socialist state had encouraged women to stay in the work force as much as possible and had made abortions freely available. West German women's groups, as well, had vociferously lobbied and fought for a reform of the infamous S 218 (the old abortion law) for decades and now presented a strong voting constituency for the Social Democrats and the Green Party. In addition, since the opening of national borders within the European Union, "abortion tourism" to the Netherlands or England makes the enforcement of punitive and prohibitive abortion laws almost impossible—as the Irish government has discovered. The ambivalence we see in the 1995 law on abortion reflects all of these perspectives, but it is the direct outcome of a political compromise between Germany's political parties, religious groups, feminists, abortion activists, legislators, and high court judges. This compromise has made it difficult to integrate a new abortion technology, Mifegyne+PG, into a society deeply divided over the morality of abortion.

The debate over legalization of Mifegyne in Germany took place within this larger political context. As in France, the United States, and Spain, German pro-life groups organized protests and consumer boycotts. The Catholic Church condemned RU 486 and its approval by European governments. Proponents of the new drug were quieter,³⁵ but much of the pro-life activism against RU 486 can be found on the internet and resembles what we have seen in France. For example, an association of primarily Christian groups wrote: "For the first time since the so-called Third Reich, Germany has

³⁵ *Ibid.*, 18. Also in Rahman, Katzive, and Henshaw, *op.cit.*, 9.

³⁶ For an example of feminist opinion, see the website of the Frauengesundheitszentrum e.V. Berlin at <http://www.ffgz.de/mife.htm>

again approved a drug the sole purpose of which it is to kill human life.”³⁷ Other groups invoked the much-recycled analogy between the “death pill” (RU 486) and Zyklon B,³⁸ a particularly striking move in view of Germany’s Nazi past. The “Party of Christians Faithful to the Bible” (PBC), published on its website an open letter to Chancellor Schroeder³⁹ by Professor Dr. Hermann Schneider, President of *Pro Conscientia*, a club which has as its mission “the protection of human life and the unborn child”. The central argument in this article is that the legalization of RU 486 is a “landmine for women”: it is deceptively touted as a gentler means of abortion, but in fact places a heavy psychological burden on a woman, since she actively participates in killing her baby.⁴⁰

Ultimately, the German government did make the controversial decision to accept Mifegyne for distribution, but only after the Social Democrats and Greens won the 1998 federal election. Public opinion was divided: polls indicate that 57% of Germans supported the government’s decision (57% of women, 57% of men; 55% of west Germans and 64% of east Germans).⁴¹ As in France, opposition to early medical abortion has not disappeared, but in contrast to what has taken place in France, Mifegyne+PG technology has made little headway in Germany. The principal reason for this is economic--a direct result of funding problems created by the 1995 abortion law and related legislation--but other problems in the administration of medical abortion services in Germany also play a role. The absence of strong governmental support for the new

³⁷ <http://www.abtreibungs-pille.de>

³⁸ The reference to Zyklon B was coined by Cardinal Joachim Meisner of Cologne.

³⁹ http://www.pbc.de/suli/1_99/ru486.htm

⁴⁰ Hermann Schneider, “Wirbel um die Killerpille RU 486” in http://www.pbc.de/juli/1_99/ru486.htm.

⁴¹ Emnid poll of 1000 Germans from October 24-25, 2000 for *Der Spiegel*.

technology can also be traced in part to German federalism, under which the 16 state governments (*laender*) are charged with implementing federal health laws.

One measure of a country's approach to abortion is whether it is treated like any other medical procedure and, especially, whether it is funded in the same manner. One of the most important compromises hammered out in the 1995 abortion law was to continue the old West German policy of treating abortion as a special case under national insurance. Unlike most insured procedures, coverage for abortions is restricted to exceptional cases, because only those cases qualify as "legal" under the terms of the law. Since health coverage for 90% of Germans is provided through national insurance "sickness funds," this means that German women must pay for abortions out of pocket or through private insurance, unless their life or health is endangered, their unborn child is severely impaired, they are the victim of rape or incest, or they can claim "social hardship" (poverty, unemployment, abandonment by a spouse, for example). Since these exceptions may be interpreted broadly or narrowly, their impact on abortion coverage is difficult to evaluate, but recent studies commissioned by Pro Familia, an advocacy group for family planning in Germany, indicate that 17% of women who have surgical abortions pay for the procedure themselves, while 67% of women who opt for medical abortions with Mifegyne cover their own costs.⁴² We can infer that many of these women are middle class, because the state bears the cost of medical care for the poor and near poor and wealthy citizens often purchase private health insurance. We can also infer that the funding provisions of German law mildly discourage abortions among middle class women with unwanted but unexceptional pregnancies.

⁴² Elke Thoss and Joachim von Baross, "Mifegyne in Germany: Were All the Efforts in Vain?", *Choices*, Vol. 28, No. 2, 2000: 5.

What discourages medical abortions in particular, however, are low payments to doctors who perform Mifegyne+PG procedures in the national health care system. These rates reflect federal laws, which set limits on physicians' fees and determine the patients' share of costs; state regulations, which further influence reimbursements to physicians and hospitals; and negotiations between sickness funds and hospital and physician collectives.⁴³ In all but two of Germany's 16 states, physicians find that the health care system's payments for an abortion patient's Mifegyne and follow-up treatment do not cover their costs.⁴⁴ Even family planning institutions such as Pro Familia, which fought hard to make Mifegyne available to German women, now uses it only if a woman can afford to cover the cost herself. With expenses for the pill alone at DM 160 and a total cost for the entire procedure limited to a maximum of DM 330, this leaves DM 170 (approx. \$80) for four doctor visits plus all medical services accompanying the procedure.⁴⁵ For prosperous Germans, whose annual income qualifies them to opt out of the sickness funds and purchase private insurance, medical abortions are more accessible. There is no statutory limit on private abortion coverage, and—even more to the point—physicians earn for private patients double the rates paid for sickness fund members. As only 8% of Germans have private insurance, however, this must have a small impact on demand for RU 486.⁴⁶

It is also important to recognize another political factor that influences the acceptance and use of Mifegyne. In order to be fully effective, it must to be administered in combination with a prostaglandin, but in Germany no well-tolerated prostaglandin has

⁴³ Center for Reproductive Law and Policy, *op.cit.*, 16.

⁴⁴ M2 Europharma, *op.cit.*

⁴⁵ Veronica Hackenbroch. Zankapfel als Ladenhueter. *Der Spiegel*, 43/2000: 93. For a slightly different breakdown of costs that arrives at the same conclusion, see Thoss and von Baross, *op.cit.*, 4.

been licensed for use in abortions. Cytotec, a prostaglandin which causes only mild contractions and would therefore be ideal in combination with Mifegyne, is approved only as a medication for ulcers. Heumann Pharma, Cytotec's manufacturer, has no intention of seeking approval to sell it for use in abortions because the company has received boycott threats that would result in painful financial losses on more lucrative pharmaceutical products. Physicians who perform early abortions using Mifegyne+PG must, therefore, make do with less desirable prostaglandins.

Given the economic and legal framework surrounding the application of Mifegyne in Germany, it has been doomed to failure. Factors at work in other countries--professional conservatism by physicians, regulations limiting medical abortions to the first seven weeks of pregnancy---also influence women's abortion choices in Germany. But these factors pale in comparison to the impact of medical funding decisions made by federal and state governments. Political compromises in the 1995 abortion bill and low funding levels for national insurance patients have made medical abortions uneconomic for physicians and clinics, creating very low demand for the drug. Demand is further reduced because pressure by anti-abortion activists has convinced the manufacturer of a key prostaglandin to keep it off the market. Where the French Ministry of Health might intervene in such a case, as it did in 1988 to bring Mifegyne to market, Germany's Ministry of Youth, Family Affairs, and Health has done no such thing. In a federal state like Germany, where the *Laender* hold most of the administrative power over health care, no central authority is committed to providing access to medical abortions. Decentralized power over health care also gives opponents of Mifegyne (and abortion in general) important avenues of influence, especially in states like Bavaria and Baden-

⁴⁶ The Center for Reproductive Law and Policy, *op.cit.*,17.

Wuerttemberg, which are governed by Christian Democrats. The result of these structural and regulatory facts of life is that only 3% of abortions performed in Germany are medical terminations. Femagen Arzneimittel, the German distributor, sells 600-700 packages of Mifegyne a month ---well below the 20,000 needed to make a profit. Special regulations on distribution have also increased Femagen's overhead costs. As a result, the company announced in December, 2000, that it would stop distributing the drug in Germany, thus ending the country's short-lived experiment with medical abortion.

Conclusion

The failure of RU 486 in Germany and the relative success of RU 486 in France highlight strong national differences in European responses to "the abortion pill." While abortion *rates* appear unaffected by the introduction of this new technology, abortion *practices* do change when non-surgical procedures are adequately compensated and effectively delivered. In addition to economic incentives, other variables that influence the use of these procedures are the organization of medical services (for example, rules that might make surgery more convenient than a drug-induced abortion), bureaucratic accounting rules (for example, performance points used to rate hospitals and clinics) and physicians' choices (for example, whether they find surgical abortion more convenient than the medical option). In most countries around the world, governments are key players in shaping policies on health and women's rights. This is especially true in Europe, where health care is usually provided through a system of universal health insurance. We find that governmental support, both legislative and administrative, is essential in facilitating access to medical abortion.

In France, where Mifegyne+PG is supported by the Ministry of Health and the medical service system, it has achieved gradual public acceptance to the point where many women now choose medical over surgical abortions. In Germany, on the other hand, legal restrictions on abortion translate into inadequate public funding for abortions in general and medical abortions in particular. Anti-abortion protest successfully keeps off the market a key prostaglandin that could make Mifegyne+PG a more comfortable procedure for abortion patients. The combined impact of these choices renders the manufacture and sale of Mifegyne uneconomic for all concerned: the manufacturer and the distributor as well as abortion patients and their medical providers.

In the German context, where abortion is less acceptable than in most of northern Europe and generous social benefits support mothers and children, other experiments to address the problem of unwanted babies have been more successful than medical abortion. One recent development is the establishment of *Babyklappen* (baby flaps), drawer-like cribs accessible from outside a building and equipped with a sensor that announces the presence of an infant. Rescuers are alerted and the child taken in. The *Babyklappen* experiment, which began in two German cities, is spreading to cities and towns all over the country. Other experiments include “anonymous deliveries,” which allow a woman to give birth in a hospital, then relinquish the child, all without identifying herself.⁴⁷ In Hamburg, a free telephone hotline has been established for desperate mothers who wish to give up an unwanted infant. *Projekt Moses*, as the hotline is called, sends volunteers to take the child into care. These grassroots efforts win wide support from Germans across the political spectrum.

⁴⁷ Hans Mackenstein, personal communication, May 2, 2001.

What lessons can be drawn from the European trends we have outlined in this paper? It is difficult to extrapolate from diverse national responses to Mifegyne+PG, but this study does suggest some provisional conclusions. The first is that medical abortion is not the revolutionary technology cheered by advocates of reproductive choice and vilified by anti-choice activists. It does not alter a woman's reproductive choices by making abortion more attractive or changing her preference for or against having children. It does not offer a solution to other reproductive problems, such as reducing the number of teenage pregnancies (better addressed through education and prevention, most family planning professionals believe). It does, however, offer a safe way to end unwanted pregnancies earlier than is currently possible using surgical methods. For women in a position to take advantage of early abortion, Mifegyne+PG is a good option.

The second conclusion is that fragmented, under-budgeted health care systems facing political pressure from anti-abortion forces are unlikely to offer broad access to medical abortion. This seems particularly relevant to the United States, where hospital mergers and closures, restrictions on public funding for abortions, and pressure against abortion providers have reduced abortion services in general. Moving beyond legalization to encourage utilization of Mifepristone will be difficult here. The organizational and political challenges are even greater than those we have documented in Britain and Germany, and the change of guard in the White House has ended support within the executive branch. American women may find, as German women have, that legalizing RU 486 offers no guarantee at all of access to medical abortion.

