

DOCUMENTING THE COST OF ABORTION IN COLOMBIA: A COMPARISON OF COSTS IN THE PROVISION OF POSTABORTION CARE AND OF LEGAL ABORTIONS

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JUSTIFICATION

In Colombia, as in most of Latin America, induced abortion is legally restricted, highly stigmatized and subject to intense debates. The controversial atmosphere around abortion permeates all levels of society and affects all women who face an unintended pregnancy. A 2006 ruling enacted by the Colombia Constitutional Court lifted the absolute ban on all abortions to allow the procedure under three limited circumstances: when a physician certifies that the life or health of the pregnant woman is threatened, when a physician certifies that the fetus has an abnormality incompatible with life, and when a pregnancy results from rape or incest that has been duly reported to the authorities. Significant legal, institutional and bureaucratic barriers have made it extremely difficult for women to exercise their right to abortion services that fall within the legal criteria, especially since October 2009, when the Council of State (Consejo de Estado, one of the four divisions of the judicial branch) challenged the ability of the Ministry of Social Protection to regulate the Constitutional Court's decision by temporarily suspending Decree 4444, which specified how the ruling was to be enforced (Consejo de Estado, 2009). The decree still remains suspended.

Therefore, despite the Constitutional Court's landmark decision, women's health in Colombia is still jeopardized by limited access to legal abortion. Recent evidence shows that 93,336 women were treated in facilities in 2008 for complications related to induced abortion (Prada et al, 2011). It also confirms that less than 1% of the 400,000 induced abortions that occur annually in Colombia were legal procedures. Abortions performed outside the law are far more likely than legal ones to be performed in unsafe conditions by untrained providers, and thus lead to complications and debilitating health consequences (Singh S et al., 2009). In particular, Colombian poor rural women continue to be disproportionately exposed to the risk of serious complications resulting from unsafe abortion, as recent evidence shows this group is most likely to self-induce or seek the help of a traditional midwife to terminate their pregnancy (Prada et al. 2011). Thus, illegal—and potentially unsafe—abortions continue to exact a heavy toll on Colombian women's well-being and the country's health system (Palacio et al. 2004).

Furthermore, for legal abortion procedures as well as postabortion care, medical providers in Colombia rely heavily on the surgical method of dilation and curettage (D&C) rather than manual vacuum aspiration (MVA) even though the former is more invasive, more time-consuming and uses up more resources than the latter. Just one-fifth of legal abortions reported

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in the previously mentioned study involved MVA, while the remaining procedures used misoprostol alone or misoprostol with D&C. In 2008, more than 90% of all facilities offering postabortion care reported more commonly treating complications with D&C than with MVA. It is important to note that the World Health Organization (WHO, 2003)—whose guidelines form the basis for the Ministry of Social Protection’s specifications for legal abortion (Ministerio de la Protección Social, 2006)—recommends the use of MVA to treat incomplete abortions that take place relatively early in pregnancy, which is when the majority of abortions in Colombia likely occur (Singh and Wulf, 1994). Colombian physicians’ longstanding preference for D&C, combined with a widespread lack of adequate MVA training and equipment, likely contributes to the high prevalence of D&C. In fact, just 11% of facilities had MVA equipment in late 2007 (Guerrero, 2007). This overreliance on D&C is found in both public and private facilities and thus increases unnecessary and avoidable health system costs.

In Colombia, legal abortion services are included in the insurance package of both types of health insurance systems: subsidized and contributive. Managers of health care enterprises at the regional and national level have been arguing that the inclusion of legal abortion in the health plan increases health system costs; however, to date, there has been no evidence to either support or refute their claims. New evidence is needed to demonstrate the comparative costs of legal abortion vs. the costs of treating abortion complications due to unsafe abortion, as well as investigate the extent to which using a modern (MVA) vs. an older (D&C) technique represents lower costs to the health system. This study is the first of its kind in Colombia—and among few in the world—to empirically measure and compare the costs of providing: (i) PAC versus legal abortion; and (ii) the cost of using MVA versus D&C techniques in PAC services and in legal abortion. Our central hypotheses are that estimates for the various procedures will vary significantly, that at present the most costly approaches to treat complications are being used in Colombia, and that legal abortion is a procedure that will save funds in the health system overall. If findings from this study follow our hypothesis, the availability of legal abortion represents monetary savings to the system compared with the treatment of complications from clandestine abortions. Furthermore, more savings would be possible by using effective and less costly alternative methods of PAC provision such as MVA (with the aim of improving access to quality abortion services in the country.)

The current study on costs builds on findings from a recent study that estimated the incidence of abortion (both legal and illegal) and abortion morbidity at the national and regional level.(Prada et al, 2011).

DATA SOURCES

The study is based on data collected in a sample of 30 health facilities that provide PAC and legal abortion services. Health facilities were selected by type of facility and geographic location in order to represent variation among postabortion patients and treatment provided, as well as to ensure efficiency in data collection. Selected facilities are from tertiary, secondary and primary levels located in the five largest cities of Colombia —Bogota, Cali, Medellin, Bucaramanga and Barranquilla—, each of them representing the five main regions of the country.

The sample included 14 tertiary health facilities (four public and 10 private), 12 secondary level facilities (11 public and 1 private) and five private primary level NGOs. Public primary level facilities were not selected because they do not have the capacity, technology and the human resources to provide PAC and to perform legal abortions. Facilities from secondary and tertiary levels were randomly selected in all but one city, located in the Eastern region. Facilities were not randomly selected in this city because there were not enough facilities meeting the criteria of providing both PAC and legal services.

Two questionnaires were applied between the end of January and mid April 2012. Both questionnaires were administered to key informants from health facilities selected into the sample between the end of January and mid April 2012.

Questionnaire A collected information about personnel inputs of time, personnel wages, hospitalization costs, overhead costs, and capital costs associated with the provision of post-abortion care and of legal abortion procedures. Direct-cost data were gathered for each of five types of abortion complications—incomplete abortion, sepsis, shock, cervical/vaginal laceration, and uterine laceration/perforation. This categorization was taken from the World Health Organization's classification concerning post-abortion care (WHO 1999). Questionnaire B asked for detailed data on the quantities of all drugs, supplies and materials used in specific post-abortion treatments and legal abortion procedures. The averages of the estimates provided by respondents (in both questionnaires A and B) are assumed to yield a good approximation of the true values of the various rates and amounts of specific inputs.

RESULTS

Results are not yet available, as mentioned above. Analysis is in progress and the paper will be completed by end of December 2012.

The study will provide the following estimates:

1. Cost per Treatment for PAC by type of Complication, Colombia, 2012 (USD 2012)
2. Cost per Case for Post-Abortion Care and for the Provision of Legal Abortion Services according to level of facility and sector, Colombia, 2012 (USD 2012)
3. Cost per Legal Abortion case, according to technique used, Colombia, 2012 (USD 2012)
4. Overhead and Capital Components of PAC and of Legal Abortion Services: Cost per Case (USD 2012)
5. Total Costs at the National Level of Post-Abortion Care by Facility Level and Type of Complication (USD 2012)
6. Total Costs at the National Level of Legal Abortion Services by Facility Level and Type of Procedure used (USD 2012)

IMPLICATIONS FOR POLICY

The new estimates will allow us to verify if the cost of legal abortion is lower than the cost of treating complications due to unsafe abortion as well as investigate less costly alternative methods of PAC provision. We hope that findings will stimulate policies and programs that would reduce costs to the government and provide health services to women using more effective PAC methods.

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