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The Economics of Abortion Access in the US
RESTRICTIONS ON GOVERNMENT FUNDING FOR ABORTION IS THE POST-ROE BATTLEGROUND

By Marlene Gerber Fried

Sarah is a 31-year-old Alaskan mother who works full time, making $1,000 a month. She has no health insurance. When she was 15 weeks pregnant and unable to get an abortion in Alaska (where there are only three abortion providers and none perform abortions after 14 weeks), she had to use her rent money to fly to Washington state to get one.1

In 2005, more than three decades after the Roe v. Wade decision legalizing abortion, there are thousands of "Sarahs" each year - women of all ages, races and ethnicities, religions, women in prison, in the military, women who are single and married. The only thing these women have in common is that they cannot afford to pay for the abortions they need and want. This "Sarah" was one of the fortunate women who, with financial assistance from grassroots abortion funds and a friend who provided a place to stay, was able to overcome the barriers and obtain an abortion. Too many others in her situation are not as fortunate. While this network of abortion funds helps thousands of women each yeaer, it cannot meet the enormous need of all the women like Sarah.

This problem is getting worse - even though abortion rates are dropping, they continue to rise for poor and low-income women. 2 Abortions are economically out of reach for so many women - primarily because of restrictive laws and policies. In order to more fully understand the financial barriers to abortion access, we need to examine the restrictions placed on abortion funding, the cost of abortion and the history of advocacy for abortion funding.

RESTRICTIONS ON GOVERNMENT FUNDING FOR ABORTION

The major reason for the economic barriers to abortion is the restrictions on funding through laws and public policies that began soon after Roe v. Wade and continue today. Prohibiting abortion funding by the federal government and the states has been a key target of the antiabortion movement. While its ultimate goal is to make abortions illegal for all women and under all circumstances, the primary strategy has been curtailing access through laws, regulations, executive orders, violence and even murder.

In the first years of legal abortion, federal Medicaid paid for about one-third of all abortions-294,000 in 1977.3 However, since 1976 when Congress passed the Hyde Amendment prohibiting the use of Medicaid funds for abortion except in cases where the life of the pregnant woman is at stake, the federal government pays for virtually no abortions-267 in 1992.4 Thirtythree states have also banned the use of state funding for abortions. In those states less than one percent of abortions are paid for with state funds, in contrast to 27 percent of abortions paid for by states without such restrictions.5

Even during the Clinton administration, when it seemed that the basic constitutional right to

abortion was safe, access was eroded. Although Clinton omitted the Hyde Amendment from his 1993 budget proposal, his aides stressed that he wouldn't object to congressional restrictions on abortion funding so long as rape and incest were exempt. And in 1993, the Hyde Amendment was passed by a large margin, 255178, although the restrictions were slightly eased to allow funding for abortion in cases of rape and incest, as well as cases where the woman's life was in danger.

When the conservatives swept into Congress in the 1994 "Gingrich Revolution," the Republicans stepped up their attacks on abortion funding. They barred abortion coverage from federal employees' health insurance, outlawed the use of military hospitals for abortion, banned federal prisons from funding abortion and eliminated 35 percent of aid to family planning programs, all in the name of protecting taxpayers and family.6 This gain was offset by new restrictions added in 1997, which tightened the life exception and an added provision extending the restrictions to other health care benefits packages receiving federal funding.7

During George W. Bush's administrations, the attacks on all aspects of abortion access have intensified even further. With respect to funding, the 2004 Weldon Amendment (which abortion rights advocates call the Women's Health Care Denial Law) allows women to be refused abortion care and even referrals by federally funded institutions.8

THE BURDEN OF FUNDING RESTRICTIONS

Six million women of childbearing age depend on Medicaid for their healthcare.9 These are the most economically vulnerable women in our society - the poor, the young and, disproportionately, women of color. They bear the brunt of restrictive legislation such as the Hyde Amendment.

Further, all women who rely on the federal government for their health care are affected. This includes Native American women who use the Indian Health Service, women in the military and Peace Corps and women in federal prisons. For these women, Hyde has been devastating.Many women cannot obtain abortionsat all-between 18 and 35 percent of Medicaid-eligible women who would have had abortions carry their pregnancies to term.10 Even those who succeed ingetting an abortion often do so at great personal cost-borrowing money, postponing bills or using money needed for food and other basic necessities. Women without economic resources also have later abortions as they struggle to find the funding.11 Young women also tend to have later abortions.12 In these cases,women end up having to pay more for their abortions.

The reproductive rights of poor women, young women and women of color have been systematically trampled on by all of the barriers to abortion access imposed by opponents of abortion. Poor women and women of color are more likely to have an abortion than women with economic resources. Denied funding for abortions, these women also face punitive policies should they wish to become mothers or to have more children while on public assistance. "The Personal Responsibility and Work Opportunity Reconciliation Act" (the 1996 "welfare reform"law) contains many provisions constraining the reproductive options for poor women. This includes welfare caps that prohibit increased payments to women who have another child while on public assistance, "illegitimacy bonuses" which give cash to states that lower the rate of out-of-wedlock births while keeping the abortion rate down and denying immigrants health care for five years. (For more on this, see p28.)

The attacks from conservatives demonstrate their understanding that abortion rights and mothering rights are two sides of the same reproductive freedom coin. For example, the federal Medicaid program pays about 90 percent of the cost of a sterilization, thus making it the more economically viable option for a poor woman who does not want to have more children. Denying both aspects of reproductive control to poor women is a matter of racial and class discrimination as well as gender inequity.

Opponents of abortion have targeted public funding of abortion, both in order to curtail access immediately and as part of their efforts to recriminalize abortion. They have been able to use the battles over funding as moral referenda on abortion itself, thus building support for more restrictions and eventually overturning Roe . Consider Henry Hyde's remarks in the congressional debate over the Hyde Amendment: "there are those of us who believe it is to the everlasting shame of this country that in 1973 approximately 800,000 legal abortions were performed in this country.. We who seek to protect that most defenseless and innocent of human lives-the unborn- seek to inhibit the use of Federal funds to pay for and thus encourage abortion."13

THE COSTS OF ABORTION

Although the price of an abortion is beyond what many women can afford, abortion prices have not risen in the way that other health care costs have and current prices do not cover the cost of the procedure. In 1991 the average price of an abortion was about half what it had been just after legalization and remaining relatively stable, increasing only by five percent ($17) between 1997-2001.14

Today the average price of a first trimester abortion (88 percent of abortions) is $468,15 increasing after that by about $100 for each additional week of pregnancy. Abortions after 24 weeks (0.08 percent) are the most expensive-the procedures themselves are more complicated, some take two days necessitating an overnight stay. If women have to travel long distances to obtain an abortion (often due to the provider shortage) they incur additional expenses. Lynne Randall, the director of the Consortium of Planned Parenthood Abortion Providers (caps), estimates that first trimester abortions would cost $1,000-more than double the going rate- if they had kept up with medical inflation.16

Advocates had anticipated that medical abortion would be less costly, but this has not been the case. In most markets, the price of medical and first trimester surgical abortion is the same. This is partly a reflection of the actual cost to the clinics when all of the relevant overheads are factored in. While there are fewer staff costs, i.e. less time with a doctor and more with nursing or unlicenced staff, many of the overheads remain the same, and the cost of the medication-mifepristone- as well as increased counseling time must also be considered. The similarity in price is also a reflection of the fact that providers do not want a woman to have to choose a procedure on the basis of cost, but rather on whether it is the right procedure for her.

Reimbursement rates have also tended to remain static. In many areas, doctors are reimbursed the same amount for an abortion at any stage of pregnancy. Thus some clinics are forced by economic considerations to provide only earlier abortions, even though they have the medical capacity to provide later ones. Since poor women tend to have later abortions, this is a further

obstacle they face in seeking abortions.

Abortions in hospital settings are more costly because most are done in emergency rooms. Since the early 1990s, abortion rights advocates, spearheaded by the Abortion Access Project, have been working to increase hospital-based abortion services and to bring down the cost. For many women, especially those who are poor and who do not live in urban centers, there are no alternatives. Almost nine in 10 counties in the US have no abortion provider at all. The decline in hospitalbased services both reinforces and is a consequence of the marginalization and stigmatization of abortion care.17

At the same time, the actual costs of providing abortions have risen astronomically, especially with the additional expenses of security and liability insurance due to clinic violence and harassment. Despite the fact that economic survival is an ongoing challenge for clinics, abortion providers have not passed the costs on to their consumers. This is the case whether or not a clinic is a nonprofit organization. Instead, clinics and providers have absorbed the increased costs, tried to cut expenses and relied on grassroots abortion funds to pay for at least some of poor women's abortions. Many even do their own fundraising to subsidize procedures. Some clinic workers actually give a percentage of their pay towards providing abortions for women who cannot afford to pay. Others chip in on a case-by-case basis. Clinic managers talk about agonizing over raising prices, even by $10.

This approach to pricing abortions is an anomaly in our privatized health care system. It reminds us that providing abortions in a hostile climate is not simply delivering health care; it is also a political act. Today, when abortion care has been so stigmatized and made dangerous by the extremists in the antiabortion movement, most of those involved in abortion provision do so out of a commitment to women's health.

The reality of the economics of abortion is in sharp contrast to the stereotypes of abortion providers as greedy profiteers. Before legalization, these images of "abortionists" as back alley butchers who exploited and harmed women were widely promulgated. Carole Joffe, a professor of sociology at the University of California, Davis, notes that many of the doctors who provided abortions before Roe were at pains to distinguish themselves from these negative portrayals. These doctors reduced their fees or waived them all together as part of their commitment to providing abortions to all women who requested them.18

THE PROCHOICE MOVEMENT AND ABORTION FUNDING

Within the feminist movement, there have been several efforts to advocate for abortion funding. Even before Roe v. Wade , while some activists focused primarily on legal change, access was the key concern for others. In the late 1960s, the cost of an abortion was around $300 (equivalent to more than $3,000 today), with some procedures costing $1,000 and more.19 Laura Kaplan, author and former member of the Jane Collective (a feminist underground abortion service which provided 11,000 abortions to women in Chicago between 1969 and 1973) notes, "The cost of abortion was a constant problem, since few women, regardless of their economic status, could easily manage $500."20 The women in Jane were constantly arguing and negotiating with their provider to get him to drop his price. After the women in the collective got rid of their " doctor" and became providers, the group dropped the price to $100, but a woman only paid what she could afford and Jane became essentially a service for poor women.

After Roe , the women's health movement played a significant role in making legal abortion services more accessible and women-oriented. At that time few physicians had experience providing abortions in outpatient settings. Women's health activists worked with physicians and clinics, establishing feminist referral services (as opposed to commercial ones), monitoring costs, developing the system of counselors as patient advocates21 and creating alternative institutions. It is estimated that there were about 50 women-controlled health clinics organized during the 1970s. These clinics were committed to providing free or low-cost services to women and were critical of the capitalist medical system.22 Unfortunately, most of these clinics no longer exist, casualties of the economics of that system.

In contrast, the mainstream prochoice movement has never placed abortion funding and access in the forefront of its political agenda, focusing instead on the legal right. For example, when the Hyde Amendment was first passed, there was no major mobilization opposing it. Since legalization had been its political focus, after Roe it appeared that the battle was over. The prochoice movement essentially did not exist in the early years of legalization. When it re-emerged in the 1980s to fight the onslaught from the antiabortion movement and the right wing, the movement was defensive in its approach and narrow in its mission. In an effort to widen their base of support, the large mainstream groups like naral and Planned Parenthood tried to woo more conservative voters who opposed both banning abortion and public funding for it. They framed abortion rights in terms of privacy and individual liberty, with restrictions on abortion criticized as encroachments by big government on individual liberty. In subsequent battles over restrictions, this libertarian spin was used as a justification for denying public funding.

There have been important efforts focused on abortion funding outside the mainstream prochoice movement. In 1993, the National Black Women's Health Project organized care, the Campaign for Abortion and Reproductive Equity. They created a diverse coalition of more than 300 groups who worked to repeal Hyde. Although they did not succeed, they raised the visibility of poor women's access to abortion as an important issue for the prochoice movement. In 2000, building on the earlier advocacy effort, the National Network of Abortion Funds created care 2000, the Campaign for Access and Reproductive Equity. The goal of this effort was to raise awareness about all of the restrictions which prevent the most vulnerable women from receiving reproductive health care.

Grassroots abortion funds also address the lack of public funding. These groups, including 110 which are part of the National Network of Abortion Funds (www.NNAF.org), provide financial assistance to more than 20,000 women annually, negotiate with clinics for lower prices and even free care and advocate for changing the law. These significant efforts help, but do not fill the enormous gap in access caused by Hyde and the other restrictions mentioned here.

The failure to make abortion funding and access more prominent in the prochoice agenda has accentuated race and class divisions. The history of compromising the rights of more vulnerable women has created a political fissure that weakens the movement. It signals to poor women and women of color that the movement is not prepared to fight for their rights.

There are several reasons for this failure. As mentioned above, the mainstream prochoice movement tried to draw in more conservative voters by creating a prochoice position that allows support for legal abortion without necessarily supporting public funding. In addition, the

mainstream movement has been primarily concerned with the legal right to abortion, rather than questions of access. This reflects both the fact that the initial strategy was to change the law and, since the 1980s, the movement has had to fight a backlash determined to recriminalize abortion. In short, the legal right to abortion although won, is not secure. This changed under the Clinton administration where we finally saw a greater focus on access, although even then, not on access for low-income women. In general, the liberal conception of rights demands that the government dismantle obstacles to exercising rights but does not call for the government to take affirmative action to create the enabling conditions required for rights to be exercised-or, as some would say, for rights to be meaningful. There is then a class and race dimension to the very understanding of what it means to have a right-for women with relative economic privilege, restrictive laws are the barriers to access, not lack of funding. Thus the language of choice appeals to those who see themselves as having choices, but does not have much resonance for those who do not.

Today there is a growing recognition that a broader movement is needed to fight the onslaught of antiabortion initiatives coming from the right wing. As the prochoice movement rethinks its priorities, goals and messages in a context of shrinking political possibilities, it is once again at a political crossroads. While there are calls for retrenchment and truncating demands, groups organized by women of color such as those in the Sister Song Women of Color Reproductive Health Collective (www.sistersong.net) give us a better model.23 My hope is that the prochoice movement will follow their approach of inclusion, expansion and prioritizing the rights and needs of those women on the margins. This would place abortion rights solidly in the camp of social justice and human rights, instead of individual choice and small government.

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ENDNOTES

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