5-2020

No Choice: At The Crossroads Of Poverty And Decreasing Abortion Access

Marja-Leena Aaltonen

Marja-Leena Aaltonen
May 2020

No Choice: At The Crossroads Of Poverty And Decreasing Abortion Access

I. INTRODUCTION

As lawmakers continue to chip away at contraception coverage, abortion rights and access, they cause further harm to pregnant people already living in poverty by preventing them from obtaining affordable and timely abortions. From insurance coverage bans to waiting periods, and now increasing criminalization of people choosing to self-manage ending their pregnancies with medication, lawmakers are effectively increasing the number of people living in poverty at the same time they reduce options and access to reproductive healthcare.[1] Instead of making more hurdles, legislators should be clearing needless legal impediments to getting the healthcare, specifically the abortion care, which people need.

The continuing limitations and restrictions placed on accessing abortion disproportionately impact those living in poverty. The rich will always be able to access abortion while many of this country's poor already cannot.[2] Medication abortion is the most cost-effective and safest way for pregnant people to self-manage their abortions, provided they can access the protocol early enough in the pregnancy.[3]

This paper will briefly review a portion of current abortion law in the United States and then focus on the problem through a lens of poverty with regard to access. Then the discussion will turn to lawmakers' and religious interests' interference in family planning decisions. Finally,

[1] *See* Gretchen Borchelt, "THE IMPACT POVERTY HAS ON WOMEN'S HEALTH," 43 Human Rights 16, 2018.
[2] Frances Raday, "Women's Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash, and Regressive Trends," United Nations Human Rights Working Group on Discrimination Against Women In Law And Practice, p2.
[3] *See* "Medication Abortion," Guttmacher Institute, November 2019, https://www.guttmacher.org/evidence-you-can-use/medication-abortion#

I offer two steps toward making abortion more accessible to all but especially toward mitigating the costs of accessing abortion.[4]

II. Abortion Rates are at historic lows, but restricting access to abortion is not the cause.

Abortion rates in 2017 hit historic lows since legalization in 1973.[5] However, birthrates also declined,[6] indicating fewer people had become pregnant rather than more people choosing to give birth or not finding access to timely abortion. In other words, restriction of abortion access is not effective to reduce the number of abortions performed in the US. Studies show that the majority of the decline in the abortion rate from 2011-2017 happened in the minority of states which did not adopt any new restrictions.[7]

In 1973 the Supreme Court recognized a constitutional right to abortion in deciding *Roe v. Wade*.[8] The Court has continued to affirm the fundamental right to abortion, as in *Planned Parenthood v. Casey*[9] and in *Whole Woman's Health v. Hellerstedt*.[10] However, in the 2020

[4] This paper was completed in April 2020 when the COVID-19 pandemic put California and others states under Shelter-In-Place orders. While several governors have already issued state executive orders halting all abortions as being non-essential, the volatility of the medication abortion debate, especially in Texas, has proven too unstable to discuss at this time. The arguments here however, hopefully aid in the fight to extend medication options to pregnant people in all states, especially during this time when travel has been limited.
[5] Jones RK, Witwer E and Jerman J, Abortion Incidence and Service Availability in the United States, 2017, New York: Guttmacher Institute, 2019, https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017. Rates in 1973 were 16.3 abortions per 1,000 women aged 15-44 while in 2017 had fallen to 13.5 per thousand.
[6] *Id.*
[7] Nash E and Dreweke J, The U.S. Abortion Rate Continues to Drop; Once again, State Abortion Restrictions Are Not the Main Driver, 2019, Guttmacher Policy Review https://www.guttmacher.org/gpr/2019/09/us-abortion-rate-continues-drop-once-again-state-abortion-restrictions-are-not-main. 57% of the 2011-2017 decline in the number of abortions happened in those 18 states not adopting any new restrictions on abortion, including California which actually increased access. Similarly, states that added clinics also saw declines in abortion rates.
[8] *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973).
[9] *Planned Parenthood v. Casey*, 505 U.S. 833, 112 S. Ct. 2791 (1992).
[10] *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

spring term, the Court heard arguments in *June Medical Services v. Russo*[11] despite the law in question being identical to the one overturned in *Whole Woman's Health*.[12]

A. Under the guise of "protecting women" these so-called TRAP laws[13] are thinly veiled attacks on abortion access and care, providers, and physical clinic buildings.

Whole Woman's Health challenged and overturned two provisions of a Texas statute; the "admitting- privileges requirement" and the "surgical-center requirement."[14] Doctors performing or inducing abortions were required to have current admitting rights at a hospital not more than 30 miles from the place of the abortion.[15] Surgical-center requirements essentially meant an abortion facility needed to meet the state's standards for an ambulatory surgical center. The former precipitated 19 of the 40 Texas clinics to close in anticipation of having no physician with admitting privileges.[16] The latter condition meant that all but nine or ten of the state's 40 clinics would have to shutter.[17] The Court remanded the case, holding that the law put an "undue burden" on women's constitutional rights to abortion.[18]

Louisiana Act 620 passed in 2014 and mirrors the Texas statutes reviewed in *Whole Woman's Health* exactly. In March 2020, *June Medical Services v. Russo* brought the same question back to the Supreme Court but also added a further challenge to standing under Article III. The underlying facts about clinic and physician numbers in Louisiana however are even more extreme. Five abortion clinics reduced to three by the time the case was filed and

[11] *June Med. Servs. L.L.C. v. Gee*, 140 S. Ct. 35 (2019). This case name was changed to v. Russo when the Rebekah Gee, Secretary, Louisiana Department of Health and Hospitals left the position and Stephen Russo was named Interim Secretary.
[12] *Whole Woman's Health, supra* note 10.
[13] Target Regulations of Abortion Providers.
[14] *Whole Woman's Health, supra* note 10 at 2296.
[15] Center for Reproductive Rights "Whole Woman's Health v. Hellerstedt" June 28, 2016, https://reproductiverights.org/case/whole-womans-health-v-hellerstedt
[16] *Id.*
[17] *Id.*
[18] *Whole Woman's Health, supra* note 10 at 2318.

projections show only one would remain if the law were upheld.[19] The 10,000 or so abortions performed annually in Louisiana would fall to the one doctor remaining of the six who were performing abortions in the state at the time of filing.[20]

The Fifth Circuit ignored the Supreme Court's holding in *Whole Woman's Health* and the Supreme Court granted certiorari to *June Medical Services*. In addition to the two requirements copied from *Whole Woman's Health*, this case also was consolidated with the challenge by Louisiana of the clinics' and physicians' standing to assert constitutional claims of their patients.[21] Should this standing challenge decision upend Article III third-party standing rights, the precedent might upset a number of areas where those with means have challenged laws on behalf of those without means.[22]

These clinic closures and doctor denials have great impact on pregnant people seeking abortions. In Louisiana, if the three remaining clinics close because of this law, 71% of women in the state will have to drive over 150 miles to receive abortion care.[23] When people have to travel that far, and abide by waiting period laws, costs soon become insurmountable. These costs include lost wages, childcare, and travel costs.

---

[19] June Medical Services LLC v Gee Backgrounder, Center for Reproductive Rights, New York, NY, https://reproductiverights.org/sites/default/files/2019-09/June Medical Services Backgrounder, September 2019 (002).pdf
[20] *Id.*
[21] *Id.*
[22] In addition to areas of contraception and abortion where doctors have sued on behalf of patients, many cases allow standing to third parties who demonstrate a requisite degree of injury to themselves and circumstances prevent the injured parties from asserting their rights themselves. E.g., *Barrows v. Jackson*, 346 U.S. 249, 73 S. Ct. 1031 (1953), where a white defendant sued for breach of a restrictive covenant against Blacks was held to have standing to assert the rights of the Blacks whose constitutional rights were infringed. "Standing to Assert Rights of Others." Cornell Law School Legal Information Institute, https://www.law.cornell.edu/constitution-conan/article-3/section-2/clause-1/standing-to-assert-the-rights-of-others
[23] Abortion Access in Louisiana, Advancing New Standards In Reproductive Health, UCSF, San Francisco, CA, https://www.ansirh.org/sites/default/files/publications/files/abortion_access_in_lousiana.pdf

B. Enacting Delays To Abortion Access Until It Is Too Late Dismisses Bodily Autonomy.

Waiting period laws are those that require a pregnant person seeking an abortion to come to the clinic, gather information and register for an appointment two or more days later with the intent of giving the person "time to think." People who have decided to seek an abortion are confident[24] about their decisions so these delay-tactic laws are not evidence-based.

Often, waiting periods can more than double the costs of travel to the clinic.[25] Couple those costs with the increasing costs of the abortion procedure itself and soon many people are priced out of the care they seek. Worse, waiting period delays increase the gestational age and as that age grows, so does the cost, and ultimately the availability, of procedures based on the stage of pregnancy.[26] When turned away from abortion care, individuals bear not only a child but other significant burdens as well.

The U.S. Turnaway Study, done in 2017 at UC San Francisco, showed the enormous burden placed on pregnant people who are turned away from the abortion care they want and need. Families fall into poverty and existing children in the family are more likely to miss developmental milestones.[27] As a supplemental study, the National Bureau of Economic Research completed additional research looking at the Turnaway study's participants' financial data like credit reports which showed a majority of the women were in poverty.[28]

---

[24] "Turnaway Study" fact sheet, Bixby Center for Global Reproductive Health, UCSF. https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf. *See* note 27 (95% of women said abortion was the right decision for them).
[25] Waiting Periods For Abortion, Guttmacher Institute, January 2020, https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion.
[26] Borchelt, *supra* note 1 at 18.
[27] Diana Greene Foster, ANSIRF UCSF, San Francisco, CA, https://www.innovating-education.org/2017/01/explained-turnaway-study/ The full results of the study have been collected into a book available June 2, 2020. "The Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having – or Being Denied – an Abortion."
[28] Sarah Miller, Laura R.Wherry, and Diana Greene Foster, "The Economic Consequences of Being Denied an Abortion," NBER Working Paper No. 26662, January 2020, JEL No. I1,I18

Telemedicine could be a solution to overcoming the long distances to abortion clinics. Medication abortions can be safely, easily, and effectively administered via telemedicine channels.[29] In the period from 2014 to 2017 the number of medication abortions actually rose despite the total number of abortions declining.[30] Medication abortions are becoming a preferred option for more people than previously. However, policy barriers are increasingly limiting this option.[31]

The UN Treaty Monitoring Bodies have identified a Right to Health, declaring that countries have an obligation to ensure access to WHO-listed essential medicines including those for inducing abortion.[32] The WHO consolidated guideline on self-care interventions includes recognition of an individual's right to practice medication abortion without direct doctor or other healthcare provider supervision.[33] This is in essence, self-managed abortion. A pregnant person could take the two-step medication protocol in the comfort of their own home, with their support network around them and not have to deal with medical staff, facilities, or bills beyond procuring the medication.

The US Food and Drug Administration (FDA),however, imposes a Risk Evaluation and Mitigations Strategy (REMS) on mifepristone,[34] meaning distribution is limited to registered

[29] Megan K. Donovan, Guttmacher Policy Review, "Improving Access to Abortion via Telehealth", 2019, https://www.guttmacher.org/gpr/2019/05/improving-access-abortion-telehealth
[30] Jones et al. ***supra*** note 5. Medication abortions accounted for 339,640, or 39% of all abortions in 2017, which was a 25% increase from 2014.
[31] Donovan, ***supra*** note 29.
[32] Center for Reproductive Rights, "Law and Policy Guide: Availability, Accessibility, Acceptability and Quality Framework" https://reproductiverights.org/law-and-policy-guide-availability-accessibility-acceptability-and-quality-framework
[33] ***Id.***
[34] Mifepristone is the first in the two-drug regimen. It acts to block progesterone which is needed for a pregnancy to continue. Misoprostol is the second drug. It induces the contractions and ends the pregnancy.

providers in clinics, hospitals, and medical offices.[35] This would not appear to be burdensome but unlike almost any other medication, mifepristone cannot be dispensed by a pharmacy. Rather, it must be sought out from a registered provider who in turn has to have passed the "stringent registration and stocking requirements."[36] These hurdles limit the number of providers thereby limiting access and often delaying, even preventing, a pregnant person from accessing a medication abortion.[37] Telemedicine is not compatible under FDA guidelines.

Family planning reduces poverty. When a person of child-bearing ability can decide for themselves when, whether, and how they want to have a family, not only do they have bodily autonomy, but they and their families have better quality of life.[38]

III. AS RELIGIOUS INTERESTS WORK TO PREVENT ACCESS TO ABORTION THEY ALSO KEEP FAMILIES IN POVERTY

Religious interests in the United States are gearing up to not only limit abortion, including medication abortion, but also contraception. Multiple high-level government positions have been filled by people who have declared they simply do not believe in contraception or believe that contraception is dangerous. For example, the U.S. Department of Health and Human Services former program chief Teresa Manning believes "contraception doesn't work."[39] Trump-appointed federal Judge Wendy Vitter believes that abortion causes breast cancer.[40] Katy Talento, Member, White House Domestic Policy Council has written that using birth control

[35] Self-Managed Medication: Expanding the Available Options for U.S. Abortion Care, Guttmacher Institute, October 17, 2018, https://www.guttmacher.org/gpr/2018/10/self-managed-medication-abortion-expanding-available-options-us-abortion-care
[36] *Id.*
[37] *Id.*
[38] BOOK REVIEW: Pregnancy, Poverty, and the State, The Poverty of Privacy Rights, BY KHIARA M. BRIDGES, STANFORD UNIVERSITY PRESS, 2017, 127 Yale L.J. 1270, 1273
[39] Christine Grimaldi, "Azar Confirmation Unlikely to Right Trump's 'Badly Off-Course' Health Department," January 24, 2018, https://rewire.news/article/2018/01/24/azar-confirmation-unlikely-right-trumps-badly-off-course-health-department/
[40] Bess Levin, "Trump Judge Who Endorsed Theory Abortion Causes Cancer Confirmed By Senate," May 16, 2019, https://www.vanityfair.com/news/2019/05/wendy-vitter-abortion

causes "miscarriages of already-conceived children," and risks "breaking your uterus for good"—both false statements.[41] As the current administration dismantles Title X and reinstates the Global Gag Rule, women[42] around the world are increasingly not informed about their options for abortion. Trump's attempt at removing contraception from insurance coverage at a national level is before the Supreme Court this term. Justice Thomas has made it very clear that the right is gunning for birth control. Dissenting *in Box v. Planned Parenthood of Ind. & Ky., Inc*,[43] Thomas wrote 20 pages falsely equating modern day family planning (contraceptives) with eugenics.

In 1969 Congress debated enactment of Title X, a program to address contraception access for the poor.[44] George H.W. Bush declared family planning a public health matter and Nixon signed the legislation.[45] Shortly after Trump gained the office of President, the Republican-held Congress "gutted Title X", which in turn allowed states to refuse reimbursement to abortion providers even for non-abortion services like cancer screenings, STI testing, and contraception.[46] The House Committee on Appropriations subsequently approved an Act scheduled to defund the Title X program.[47] As of this writing however, funding has remained the same since 2014.[48]

---

[41] "The Trump Appointees Who Want To Take Your Birth Control", Planned Parenthood Action Fund, https://www.plannedparenthoodaction.org/fight-for-birth-control/facts/meet-trump-appointees-who-want-sabotage-your-access-birth-contro
[42] While I use "women" here, I do recognize and try to use "pregnant people" as much as possible to include those who do not identify as women but may still be child-bearing.
[43] *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780 (2019).
[44] Bridges, supra note 38 at 1274.
[45] *Id.*
[46] *Id.*
[47] *Id.*at 1275.
[48] U.S. Department of Health & Human Services, Funding History, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html

Poverty impacts ability to access abortion while at the same time inability to access abortion exacerbates poverty.

The Hyde Amendment, which bans any federal funds from being spent to perform abortions, ensures that people under federal health plans have to pay out-of-pocket for abortion care. Federal health plans cover the military, federal prisons, the Peace Corps, as well as federal employees and everyone on Medicare and Medicaid.

The *Hobby Lobby* decision allowed employers to decline to cover contraception if they so closely held a religious belief against it.[49] Under the auspices of religious freedom, companies are now able to deny contraceptive coverage to employees. Since the US relies largely on employer-provided healthcare, this means many people will be stuck paying out-of-pocket for contraception.

If someone cannot afford to pay for regular, consistent birth control, they risk pregnancy. Even an early – within the first 10 weeks – abortion by medication can easily cost $500.[50] Considering almost 40% of American households do not have enough in savings to cover an unexpected $400 expense,[51] the poverty and abortion access connection quickly coalesces. Out-of-pocket costs for uncovered abortion in the Turnaway Study were $575.[52] For more than half the participants these out-of-pocket expenses totaled more than one-third of their monthly income.[53] While one saves and scrapes together the cost of the abortion procedure, the gestational age is constantly growing. This means that more medically involved procedures may be required, which in turn cost more. The out-of-pocket cost is closer to two-thirds of the study

[49] *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 690 (2014).
[50] Guttmacher Institute, "Induced Abortion in the United States" September 2019, https://www.guttmacher.org/fact-sheet/induced-abortion-united-states
[51] Report on the Economic Well-Being of U.S. Households in 2018, Board of Governors of the Federal Reserve System, May 2019, p10 https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf
[52] Foster et al, *supra* note 24.
[53] *Id.*

participants' income when the abortion was after 20 weeks.[54] It is a sliding scale in the wrong direction for an impoverished pregnant person seeking abortion.

Further, if an abortion is not obtained when needed, then it is likely that another child will be added to the family.[55] Children born when a desired abortion was unobtainable, experience three times the rate of poor mother-infant bonding.[56] Those turned away from clinics and denied abortions saw their debts over 30 days past due increase by 78% compared to those who had obtained abortions.[57] This group also had higher rates of unemployment, and receipt of food assistance, and were more likely to receive TANF benefits for four years.[58] Having a child also impacts one's ability to find and keep full-time employment.[59]

Having rights without access means having no rights. Jill Adams, founding executive director of the Center on Reproductive Rights and Justice at UC Berkeley School of Law explains, "The government has failed to adequately protect the liberty right created in Roe because it has done nothing to ensure access to abortion for people living in poverty--denying equal dignity to people who cannot afford to pay for an abortion out-of-pocket."[60] Post-*Obergefell*, "a government practice that limits options available to members of a particular group

---

[54] *Id.*
[55] The Turnaway Study found that of the 231 women who were turned away (not able to receive an abortion at the Facility Foster studied) 20 percent found abortion care elsewhere, while 9 percent put their children up for adoption. Joshua Lang, "What Happens to Women Who Are Denied Abortions?," June 12, 2013, https://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?_r=0
[56] Foster et al, *supra* note 24.
[57] Miller et al, *supra* note 28.
[58] *Id.* at 27.
[59] Foster, ANSIRH, "Socioeconomic outcomes of women who receive and women who are denied wanted abortions," August 2018, https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf Six months after being denied an abortion women had more than three times greater odds of being unemployed than women who were able to access an abortion. Those denied abortions also were more likely to be enrolled in public safety net programs.
[60] SYMPOSIUM ISSUE OF GENDER AND THE LAW: ARTICLE: AND DAMNED IF THEY DON'T: PROTOTYPE THEORIES TO END PUNITIVE POLICIES AGAINST PREGNANT PEOPLE LIVING IN POVERTY, 18 Geo. J. Gender & L. 283, 312, (2017).

need not have been deliberately designed to harm the excluded group if its oppressive and unjustified effects have become clear in light of current experience and understanding."[61]

III. RECOMMENDATIONS: CODIFICATION

A. Bodily Autonomy

Congress needs to act to codify women's bodily autonomy immediately. By recognizing a woman's right to make her own bodily decisions, government could change the direction toward progress instead of further oppression of more than half the population. Part of that policy shift would be to also codify the constitutional right to choose abortion, by safe, medical and medication practices.

The UN Working Group on Discrimination Against Women In Law and Practice emphasized the need for bodily autonomy as a human right, when it stated that "the necessity of putting women's human rights at the center of the policy considerations regarding termination of their pregnancy is obfuscated by the rhetoric and political power behind the argument that there is a symmetrical balance between the rights to life of two entities: the woman and the unborn."[62]

B. The Right To Safe, Medical And Medication Abortions Will Protect Pregnant People Seeking Abortions From Sinking Into Poverty

Medication abortion needs to be legalized across the nation. The process already started with FDA approval. Decriminalizing the use of medication in self-managed abortion would make a very clear statement of trust for women. The mifepristone/misoprostil protocol is safer than some over-the-counter options currently available. The FDA should remove the REMS restrictions so that, as the WHO suggests,[63] women may self-evaluate whether they can use the

[61] *Id.*
[62] Raday, *supra* note 2.
[63] Guttmacher Institute, *See supra* note 3.

medication, procure it via telemedicine and a local pharmacy, and then proceed with the regimen at home.

Medication abortion is easily, efficiently, and effectively administered through telemedicine which would eliminate the issues of great distance between the majority of the child-bearing population and a functioning clinic. Eliminating the economic burdens of clinic visits, delayed care, and potential exclusion from access saves sorely needed funds for many of the women who are uncovered by insurance and needing abortions.

IV. CONCLUSION

In our democracy, of, for, and by the people, our Congress needs to act to reflect the beliefs and will of the majority of the population.[64] The right to abortion should not be shaped primarily by a panel of only nine people who are not elected but appointed for life and are increasingly partisan. Rather, the fundamental right to plan one's family should be codified by the legislature into a Constitutional Amendment. The ERA, or a new version of it, would be an excellent place to include such a right to bodily autonomy. For far too long, women have been policed by the elected representatives in Congress and it is no longer tolerably incrementing toward equality. We need action, concrete and affirming, to show that women, poor or not, can and should make choices about their bodies, their families, and their lives.

[64] Ashley Kirzinger, Lunna Lopes, Alina Salganicoff, Brittni Frederiksen, Cailey Munana, Usha Ranji, and Mollyann Brodie, "KFF Poll: Public Opinion and Knowledge on Reproductive Health Policy," Kaiser Family Foundation, May 3, 2019, https://www.kff.org/womens-health-policy/poll-finding/kff-poll-public-opinion-and-knowledge-on-reproductive-health-policy/ ("Most Americans – including three-fourths of women ages 18-44 – say they are concerned (either "very" or "somewhat") that access to women's reproductive health and preventive care services may be limited by the new rules that don't allow clinics that provide abortions or refer for abortions to receive federal funding.")