

The Impact of Government Programs on Reproductive Health Disparities: Three Case Studies

By Heather D. Boonstra

During the last several decades, the health of Americans overall has steadily improved. However, many low-income, poorly educated or disabled Americans, as well as people of color, have not benefited from many of the recent health gains for the population as a whole. Across the board, these groups are disproportionately more likely than others to struggle with diabetes, heart disease, cancer and obesity. Some groups have higher death rates from unintentional injuries and suicide than the general population, and others tend to report more anxiety, pain, sleeplessness and days of depression.

Recognizing the magnitude of health inequalities in the United States, one of the goals of the Department of Health and Human Services' *Healthy People 2010* is to eliminate health disparities. The document, which sets national goals and objectives designed to improve the public health, is part of a long line of attempts by the federal government to address inequalities. Beginning in the 1960s, initiatives such as the 1964 U.S. Civil Rights Act and the establishment of Medicare, Medicaid and community health centers were focused on reducing disparities, in relation to poverty and legal rights, as well as health care.

In the field of sexual and reproductive health, three government initiatives stand out as case studies of policies and their impact on disparities. The first examines the federally funded family planning program, which was a conscious attempt to ensure that any woman—regardless of her age, marital status, income or health insurance status—has access to the contraceptive

services she wants and needs. The second highlights the Hyde Amendment, in which the government has abdicated its responsibility to poor women faced with an unintended pregnancy. And the third focuses on a Medicaid eligibility expansion for pregnant women that revolutionized how pregnancy-related care is paid for in this country. Each of these case studies presents a starkly different portrait of government policies and the lessons that can be learned about addressing inequalities in the United States.

Family Planning Program

The 1960s was a period of rapid social change, marked by the civil rights and women's rights movements, which in themselves were focused on reducing disparities and expanding human freedoms and opportunities. Many in the civil rights and women's rights communities recognized family planning as fundamental to the drive for equality and social justice. Martin Luther King Jr. for one, lauded family planning for improving the lives of African-Americans and offering them "a fair opportunity to develop and advance as all other people in our society."

The impetus for government involvement in subsidized family planning services in the 1960s clearly reflects these social movements, as well as new developments specific to the field of sexual and reproductive health. The oral contraceptive burst onto the U.S. market in 1960 and was almost immediately adopted by millions of American women who wanted a reliable method of family planning that did not interfere with the spontaneity and pleasure of sex. Moreover, over the course of the 1960s, there was increasing recognition among researchers, advocates and

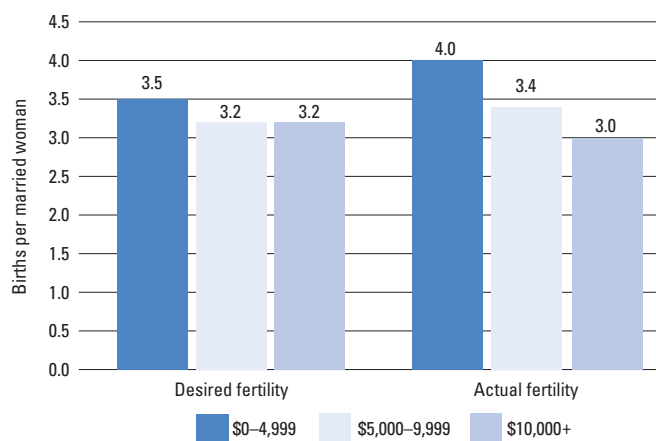
policymakers that enabling women and couples to better control the number and timing of their children would play a role in closing disparities in three key areas: poverty and government dependency, public health and human aspirations. First, numerous studies at the time documented the substantial and far-reaching economic consequences that unintended pregnancy could have—particularly for teenagers—by increasing a woman’s risk of living in poverty and reducing her ability to participate in the workforce or complete an education. (Notably, the first federal family planning grants were made by the Office of Equal Opportunity, as part of the Johnson administration’s signature War on Poverty.) Second, researchers provided evidence that closely spaced births and childbearing very early or late in the reproductive years could lead to adverse health outcomes for both mothers and their children. And, third, groundbreaking research showed that, although women at all income levels wanted about the same number of children, lower-income women continued to have more children than they desired because they lacked access to affordable and effective contraceptives (see chart).

These concerns over disparities and social justice fed into the establishment in 1970 of Title X of the Public Health Service Act, the only program devoted solely to the provision of family planning services on a nationwide basis. Introduced with bipartisan support and signed into law by President Nixon, Title X was designed to make contraceptives available to all who want them and requires that services be provided to poor clients at no cost and to other clients at a fee based on their ability to pay. The new program sought to fulfill Nixon’s historic 1969 promise that “no American woman should be denied access to family planning assistance because of her economic condition.”

Policymakers at the time recognized that publicly subsidized contraceptive initiatives can be a double-edged sword, with a potential for both liberation and oppression. The ability to decide if and when to have a child can be a central source of empowerment for individual women and couples. But history—including U.S. history—is replete with examples of deliberate campaigns to

GAPS IN FAMILY SIZE

In 1965, all women wanted about the same number of children, regardless of income level; however, the lower their income, the more children they had.



Note: In 1965, the poverty level for a family of four was \$3,130; therefore, a family income of \$5,000 corresponded to about 160% of poverty (or \$33,920 today), and a family income of \$10,000 corresponded to about 320% of poverty (or \$67,840 today). Source: Ryder NB and Westoff CF, *Reproduction in the United States: 1965, 1971*.

limit the fertility of women of color, low-income women and women with disabilities, using fertility control as a tool of social control. Recognizing that there needed to be a standard of care for the ethical delivery of services, the Title X statute from the beginning included key patient protections to ensure that participation was truly voluntary. Notably, it provides a requirement that clients must be offered a broad range of contraceptive methods from which they can make a choice; a guarantee that they would not be coerced into accepting a particular method; and an express prohibition on conditioning the receipt of government assistance on the acceptance of any contraceptive method.

Title X spurred the development of a nationwide network of clinics that has come to serve as a primary source of high-quality, affordable contraceptive services for low-income women. Family planning clinic sites—which number nearly 7,700—are located in 85% of counties in the United States and serve approximately seven million women annually, according to a 2001 Guttmacher study. (Title X, according to the most recent program data, supports roughly 4,400 of these clinics, which together serve nearly five million women.) Another Guttmacher study indi-

cates that nine in 10 family planning clients have family incomes below 200% of the federal poverty level. They are predominately white, yet because poverty status is closely linked with race and ethnicity in this country, women seeking subsidized family planning services are disproportionately women of color.

Publicly subsidized family planning services have helped millions of women avoid unintended pregnancies and the births, abortions or miscarriages that inevitably would follow. According to a 2008 Guttmacher study published in the *Journal of Health Care for the Poor and Underserved*, in 2004 alone, women attending publicly funded clinics avoided an estimated 1.4

million unintended pregnancies—600,000 of which would have ended in abortion (related article, page 24). The program also played a key role in nearly equalizing contraceptive use between the early 1980s and the mid-1990s. Earlier Guttmacher research indicates that, over this period, women of all racial, ethnic and income groups became more likely to use contraceptives, and the overall rate of unintended pregnancy dropped 18%.

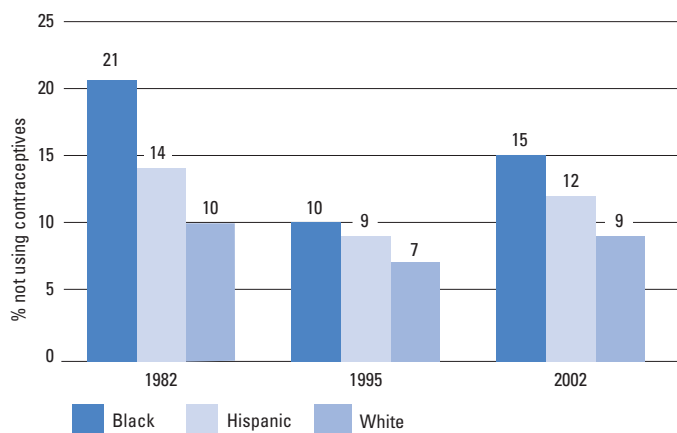
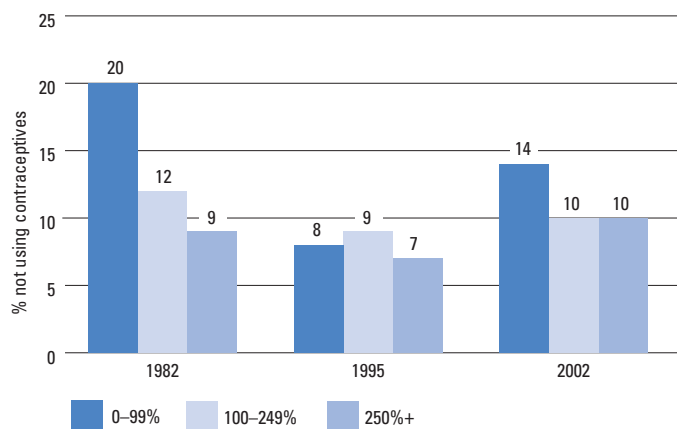
The newest data, however, show that these gains are in jeopardy, and, in fact, some key groups now appear to be losing ground. According to data from the Centers for Disease Control and Prevention (CDC), the nationwide proportion of women at risk of unintended pregnancy who are not using a contraceptive method fell from 12% in 1982 to 7% in 1995, but then rose to 11% in 2002. And nonuse has risen more sharply among poor women and women of color—those most likely to have an unintended pregnancy—than among more affluent and white women (see chart). Moreover, unintended pregnancy is becoming increasingly concentrated among poor women. According to Guttmacher research, between 1994 and 2001, the unintended pregnancy rate rose 29% among women living below the poverty level, but fell 20% among more affluent women. The disparities by race did not change over this same period. Nonetheless, black and Hispanic women continue to have higher rates of unintended pregnancy than white women, and as a result, higher rates of unintended birth and abortion (related article, page 2). In short, the individual, societal or structural influences that had been working to close disparities between the early 1980s and mid-1990s are no longer having that effect.

Public Funding of Abortion

The effort to make abortion legal in the United States was driven in large part by a concern with disparities, because poor women and women of color were always disproportionately affected by the criminalization of abortion. Even in states where abortion was illegal, women with financial means often had access to a safe, although clandestine, procedure, whereas less affluent women—who disproportionately are minorities—

PROGRESS STALLED

Contraceptive nonuse among poor and low-income women and women of color has decreased since 1982, but the newest data show these gains are in jeopardy.



Note: Among all women at risk for unintended pregnancy (those who are sexually active, fertile and not seeking to become pregnant). Source: Guttmacher Institute, 2008.

had few options aside from a dangerous, back-alley abortion. According to a series of studies on abortion in New York City in the 1950s and 1960s, the incidence of abortion was much higher among patients with private physicians than among women without their own doctor, and low-income women were more likely than more affluent women to be admitted to hospitals for postabortion care following an illegal abortion. Furthermore, one of every two childbirth-related deaths among women of color in New York City in the 1950s was due to abortion, compared with one in four among white women.

It is ironic, then, that soon after the nationwide legalization of abortion in 1973 (the year the Supreme Court handed down its decisions in *Roe v. Wade* and *Doe v. Bolton*), poor women became pawns in the congressional debate over the procedure. After failing to overturn *Roe* by persuading Congress to pass a “human life amendment” to the U.S. Constitution, abortion opponents focused on restricting poor women’s access to the procedure, by withdrawing public funding for abortion under Medicaid. “I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman,” said then-Rep. Henry Hyde (R-IL) during a congressional debate over public funding in 1977. “Unfortunately, the only vehicle available is the...Medicaid bill.”

The Hyde Amendment, enacted in 1977, bans the use of federal funds for abortion services in all but the most extreme circumstances: The current version of the amendment, established in 1997, allows federal funding for abortion only in cases of rape, incest or life endangerment. It primarily affects women enrolled in Medicaid, who amount to more than seven million women of reproductive age, or 12% of all U.S. women in that age-group. In addition, over the past two decades, Congress has enacted bans similar to the Hyde Amendment that affect the health care of other disadvantaged women, including low-income residents of the District of Columbia, federal prison inmates and Native Americans. Importantly, 17 states currently have a policy to use their own funds to pay for all or most medically necessary abortions sought by Medicaid

recipients, ameliorating the problem for poor women living in those states, but not for those living in the rest of the country.

The Hyde Amendment has had a real-life impact on poor women and their families. Various studies have shown that most poor women in need of an abortion manage to obtain one; however, many have to postpone their abortion. This delay can be substantial: Studies conducted over the last three decades show that poor women take up to three weeks longer than other women to obtain an abortion. Little wonder that, according to a Guttmacher study published in a 2006 issue of *Contraception*, 67% of poor women having an abortion say they would have preferred to have had the procedure earlier.

When asked why they were delayed after deciding to have an abortion, poor women are about twice as likely as more affluent women to report having difficulties in arranging an abortion, usually because of the time needed to come up with the money. According to Guttmacher research, poor women are often forced to divert money that would otherwise be spent on rent, utility bills, food or clothing for themselves and their children. Exacerbating her difficulties, the cost of an abortion increases the longer a woman waits to have the procedure. In 2006, the median charge for an abortion was \$430 at 10 weeks’ gestation, but jumped to \$1,260 at 20 weeks. Such delays also can have health implications, because the risk of complications increases exponentially at higher gestations.

Perhaps the most significant result of the funding restrictions, however, is that a substantial proportion of Medicaid-eligible women are forced to forgo their right to abortion and bear children they did not intend. Studies published over the course of two decades indicate that 18–37% of women who would have obtained an abortion if the government had paid for it instead continued their pregnancies. Perhaps the best such study, published in the *Journal of Health Economics* in 1999, examined abortion and birthrates in North Carolina, where the legislature created a special fund to pay for abortions for poor women. In five instances between 1978 and 1993, the fund was

depleted before the end of the fiscal year, leaving women whose pregnancies occurred after that point to fend for themselves. During those times when funding was not available, the researchers found, more than one in three women (37%) who would have obtained an abortion if the state had paid for it instead carried the pregnancy to term. As then-Sen. Birch Bayh (D-IN) observed in 1977 during one of the early congressional debates on the Hyde Amendment, “Those who do not have the financial resources have the constitutional right [to choose abortion], but a right without the ability to use it is absolutely worthless.”

Pregnancy-Related Care

It may be hard to believe today, but until the late 1970s, private insurance plans in the United States often did not cover pregnancy-related care, including basic prenatal and delivery services. Indeed, it took enactment of a federal law—the Pregnancy Discrimination Act of 1978, which requires all but the smallest employers’ health plans to cover pregnancy-related care—to change the situation. And change the situation it did: The number of workers in groups with more than 25 employees who had policies that covered pregnancy-related care jumped from 41% in 1978 to 99% in 1986, according to the Health Insurance Association of America.

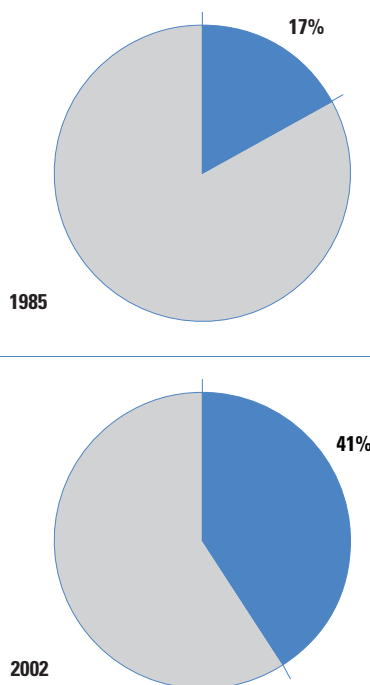
The Pregnancy Discrimination Act played a major role in ensuring that those with private insurance had coverage for pregnancy-related care, but left a gap in coverage for the lowest income Americans, who rarely have access to employer-sponsored insurance. According to Guttmacher research published in 1987, nearly 15 million women of reproductive age had no insurance for pregnancy-related care, and many low-income pregnant women faced a host of financial obstacles to care that could easily turn what is supposed to be a happy event into a period of extraordinary stress. Congress and state governments moved to close the gaps by progressively increasing the income level at which women become eligible for Medicaid-funded prenatal, delivery and postpartum care. By 1989, Congress had set a national floor for Medicaid eligibility for pregnant women: States are required to provide coverage for pregnancy-related services for

women with incomes up to 133% of the federal poverty level—far above most states’ regular Medicaid eligibility ceilings. At their option, states can include women with incomes up to 185% of poverty and even beyond.

The Medicaid eligibility expansion revolutionized how pregnancy-related care is paid for in this country. Today, fully 44 states and the District of Columbia have set income eligibility levels beyond the minimum required. Enrollment of pregnant women under Medicaid has increased dramatically under the expansions, and since 1985, the proportion of all births financed by Medicaid has soared (see chart). As might be expected, this policy change in Medicaid improved early initiation of prenatal care among disadvantaged women. The Urban Institute reported in a 2001 issue of *Health Services Research* that the proportion of women initiating prenatal care after the first trimester declined

MEDICAID BIRTHS

Changes in Medicaid policy in the late 1980s revolutionized how pregnancy-related care is paid for in this country, and the proportion of births paid for by Medicaid increased dramatically.



Sources: Guttmacher Institute, 1987, and National Governors Association, 2006.

between 1980 and 1993, falling more sharply during the period of the Medicaid expansions (1986–1993) than in the pre-expansion period (1980–1986). Moreover, the downturn is most pronounced among both whites and African-Americans with low levels of schooling. According to the authors, because income and education are closely aligned, the pattern of these changes is consistent with one of the major goals of the Medicaid eligibility expansions: to reduce delayed initiation of prenatal care among poor and near-poor pregnant women.

On its own terms, then, the Medicaid eligibility expansion has been a great success, and today, the nation is approaching universal access to coverage for pregnancy-related care. Nevertheless, the hard truth is that this policy change has not had an impact on gaps in maternal and newborn health. According to the CDC, the maternal mortality rate dropped significantly between 1950 and 2005, from 83 to 15 deaths per 100,000 live births. Yet, in 2005, the maternal mortality rate for black women was roughly three times the rate for white women—a gap that has remained relatively constant since the early 1950s, notwithstanding the Medicaid eligibility expansion or other government policies.

In addition, there is little evidence that the Medicaid eligibility expansion has had an effect on birth outcomes, and large differences in low-birth-weight births by socioeconomic group remain. In fact, according to the Urban Institute's study, for African-Americans, rates actually increased over the period of the Medicaid expansion, as did the gaps between whites and African-Americans. Today, the risk of low birth weight among black infants is more than twice that among white infants. Clearly, more research is needed to better understand what is behind the disparities in maternal and infant health outcomes.

Closing the Gaps

One thing is clear: It is easy for the government to do harm when it wishes to do so. The “success” of the Hyde Amendment shows this quite well. By making abortion more costly, restrictions on coverage of abortion block substantial

numbers of women from obtaining an abortion quickly and early in pregnancy—if at all. Moreover, these restrictions fall hardest on young and poor women and women of color.

In contrast, the Title X family planning program and the Medicaid eligibility expansion for pregnant women demonstrate how targeted government policies can have a positive impact on inequalities in reproductive health. But even the best of these have their limits. Publicly funded family planning clinics serve millions of low-income women each year, providing a range of critical preventive services and enabling women to avoid unintended pregnancies and the abortions that would inevitably follow. And the Medicaid eligibility expansion has transformed how pregnancy-related care is paid for in this country, enabling low-income women to begin prenatal care as early in pregnancy as possible in order to improve their chances of having a healthy baby. But although these policy initiatives have reduced some of the disparities faced by many disadvantaged women, they have not eliminated disparities altogether.

These and other targeted government initiatives have a limited impact on sexual and reproductive health disparities in part because they are, indeed, targeted. Rather, achieving reproductive health equity would require a multidisciplinary approach that recognizes the many problems related to access and quality of care that have affected numerous health issues, including diabetes, obesity, heart disease and cancer. Some of these barriers are financial in nature: Low-income Americans and people of color lag behind others in terms of income, employment and insurance coverage—all of which greatly affect access to health care. Other barriers relate to knowledge, history and culture: Low-income Americans and people of color are more likely than others to have low levels of education and literacy, to report a lingering mistrust of the medical community and to speak a language other than English. Still other barriers are related to the performance of the U.S. health system, such as time and cost-control pressures on health care providers, differences in geographic availability of services and gaps in medical research.

The root causes of these disparities are manifold: a long history of discrimination, too few educational and professional opportunities for disadvantaged groups and unequal access to safe, clean neighborhoods, just to name a few. There are no easy solutions to these complex challenges. Innovative strategies—looking at empowering individuals, ongoing cross-cultural education of providers, access to and quality of care, and efforts to reduce entrenched poverty and improve education—will all have to be part of the longer-term approach.

The bottom line is that even as advocates press for targeted initiatives to reduce sexual and reproductive health disparities, they need to give greater attention to the larger forces that drive disparities. Addressing social and economic disparities is critical to reproductive health. At the same time, empowering women and couples to decide if and when to have a child and enabling them to have a healthy pregnancy and baby are critical to achieving social justice. www.guttmacher.org