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ABSTRACT

The majority of U.S. abortion patients are poor women, and Black and Hispanic women. Therefore, this article encourages bioethicists and equity advocates to consider whether the need for abortion care should be considered a health disparity, and if yes, whether framing it this way would increase the ability of poor women and women of color to get the medical care they need. In order to engage with these critical questions, bioethicists must avoid abortion exceptionalism and respect patients as moral agents. Centering the conscience of pregnant people shifts our analysis away from the ethics of the act of abortion, and toward the ethics of access to abortion care. Because the Supreme Court is on the brink of shifting the question of abortion's legality to state legislatures, this is the moment for all bioethicists to clarify and strengthen their thinking, writing, and teaching in abortion ethics.

KEYWORDS

Abortion; children and families; contraception; cultural studies; health equity; justice

The vast majority of abortion-related articles I see in bioethics journals focus on the conscience of clinicians, or the moral status of embryos and fetuses. In the spirit of earlier calls for inclusion in the biosciences to researchers who worked exclusively with male mice or developed medical metrics with majority-male human subjects, this paper is a call to bioethicists to recognize the ways we may have undervalued the moral status of women in our analytic frameworks, and to deliberately integrate women into every analysis of abortion ethics.

There is a practical urgency to this conceptual corrective. If the Supreme Court shifts the question of legality in whole or in part to state legislatures, the ethics of abortion will become an even more intense subject of debate in public, academic, and clinical realms. Therefore, this is the moment for all bioethicists to strengthen our teaching, thinking, and writing in abortion ethics.

Only women[1] have unwanted pregnancies, but women are not a uniform group. The majority of U.S. abortion patients are poor women, and Black and Hispanic women (Jones and Jerman 2017). When I lecture on abortion ethics audience members often tell me they did not know this, and in this article I argue it should lead us to consider two questions: Should the need for abortion care be considered a health disparity? And if yes, would framing it this way increase the ability of poor women and women of color to get the medical care they need?

Beginning with, or at minimum accounting for, clinical and social realities is a standard starting point for ethics analysis in every other medical specialty, yet my book *Scarlet A: The Ethics, Law, and Politics of Ordinary Abortion* (OUP 2018) was partly motivated by the realization that we talk about the *idea* of abortion more than the *experience* of abortion. The degree to which centering patient values and experiences is uncommon in abortion ethics may be a product of "abortion exceptionalism"—the belief or feeling that everything about abortion care is different from other medical or social issues (Joffe and Schroeder 2021). However, succumbing to this exceptionalism hampers our ability to look at topics in abortion ethics with fresh eyes—or indeed, the same eyes we apply to comparable issues (Watson 2014; 2018b). Framing the

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[1]My frequent use of the term "women" is intended to center the history of sex-based discrimination that helps define the current status of abortion care in American medicine and bioethics. My occasional use of the word "people" is intended to acknowledge that not everyone capable of pregnancy identifies as a woman, and all people capable of pregnancy, including male-identifying and non-binary patients, need access to abortion care.

need for abortion care as an issue of health disparities shifts us from the ethics of the act of abortion to the ethics of access to abortion care, but centering pregnant people in analyses of abortion ethics does not ignore the moral status of embryos and fetuses. Instead, it flips the focus to patient conscience, respecting patients as moral agents and assigning that assessment to them. Since 1973, over 33 million American women and the clinicians who cared for them have voted with their feet to say abortion is ethical (Watson 2018a, 2019)—or at minimum ethical enough to choose abortion instead of childbearing (Foster et al. 2012; Frohwirth et al. 2018; Woodruff et al. 2018). U.S. women choose to end 18% of all pregnancies and 42% of unintended pregnancies, and if current abortion rates (which are *lower* than they were before *Roe v Wade)* remain steady, 1 in 4 women in the U.S. will have an induced abortion by menopause (Finer and Zolna 2016, Tables 1 and 2; Guttmacher Institute 2019a, 2019b; Jones and Jerman 2017). Ethicists and clinicians who accept patients' moral reasoning about their bodies, lives, and pregnancies are not "taking a side" in the abortion debate; they are refusing to participate in either forced pregnancy or forced abortion, supporting the provision of prenatal and delivery care or abortion care based on patient values, and standing in the intermediate space of pluralism.

The health disparity framework is not the same as the compelling Reproductive Justice (RJ) framework (which links the right to not have children, the right to have children, and the right to parent the children one has with dignity and in safety (Ross and Solinger 2017)), and at the end of this article I compare the strengths of each. However, their differences do not make them mutually exclusive, and bioethicists who understand both may be best positioned to support vulnerable patients.

ACCESS TO ABORTION CARE IS A HEALTH DISPARITY

The COVID-19 pandemic and the racial reckoning that followed the murder of George Floyd brought the justice issues raised by health disparities to the forefront of bioethics. We now have a wider consensus on our ethical duty to work toward ameliorating or eliminating the unjust consequences of structural racism and poverty on the body (Hutler 2022; Mithani et al. 2021). Our field's deeper commitment to responding to health disparities as a matter of justice should be integrated into our analysis of abortion ethics.

In 1948 the World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," and in 1992 Margaret Whitehead offered an elegant definition of health inequalities—health differences that are avoidable, unnecessary, and unjust (WHO 1946; Whitehead 1992). In 2010 the US government's Healthy People 2020 campaign offered the first specific definition of health disparities from a U.S. federal agency (Braveman 2014): "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; … socioeconomic status; gender; … geographic location; or other characteristics historically linked to discrimination or exclusion" (Healthy People 2020). In a journal article, the authors of this definition further explain that health disparities "are a specific subset of health differences of particular relevance to social justice because they may arise from intentional or unintentional discrimination or marginalization and, in any case, are likely to reinforce social disadvantage and vulnerability" (Braveman et al. 2011).

Half (49%) of abortion patients in the US have incomes below the federal poverty line (FPL), and another 26% have incomes of only 101–200% of the FPL (Jerman et al. 2016). The 2022 FPL for a single person is an annual income of $13,590 or less (US Department of Health and Human Services 2021). Social science research confirms the obvious connection between income and abortion. In a large national study that asked abortion patients their reasons for ending their pregnancy, 73% cited "can't afford a baby" as one of their reasons, and 23% cited it as their most important reason (Finer et al. 2005).

The majority (62%) of abortion patients are nonwhite. Black and Hispanic women are overrepresented (53% of US abortion patients versus 32% of the U.S. population) and white women are underrepresented (39% of US abortion patients versus 60% of the US population) (Jones and Jerman 2017; US Census Bureau 2022). Asian and Pacific Islander women are represented in proportion to their presence in the U.S. population (6%) and an additional 3% of abortion patients are of another nonwhite race or ethnicity (Jerman et al. 2016; US Census Bureau 2022). Unfortunately, there are no published abortion data specific to Native populations in the U.S. A significant factor explaining why Black and Hispanic women are overrepresented among abortion patients is that they

are overrepresented among low-income women, and non-Hispanic white and Asian women are underrepresented among low-income women (Creamer 2020).

Only women struggle to access medical care to end unwanted pregnancies, but I will set the gender dimension of the disparity argument aside for now because I have analyzed it elsewhere (Watson 2018a, 2021, 2022). The geographic dimension of abortion access is also beyond the scope of this article, but it both includes the familiar urban-rural dichotomy and goes beyond it (Sutton, Lichter, and Sassler 2019).

Despite the fact poor women and Black and Hispanic women are disproportionately in need of abortion care, a PubMed search[2] of "abortion and disparit*" yields very few articles (from a list of 315 retrieved) that frame the need for, or utilization of, abortion care in the U.S. as a health disparity. The pioneer on this topic is family physician Christine Dehlendorf, who has published three articles with different collaborators in the medical and public health literature (Dehlendorf et al. 2010; Dehlendorf and Weitz 2011; Dehlendorf, Harris, and Weitz 2013).

Poor women have higher *rates* of abortion (number of abortions per 1,000 women) than higher-income women. (This is due to poor women's higher rates of unintended pregnancy, which is discussed below.) However, what is rarely noted is that poor women terminate a lower *percentage* of their unintended pregnancies than higher-income women. Women with incomes 200% or higher FPL terminate 48% of their unintended pregnancies, and women with incomes 100% or lower FPL terminate 38% of their unintended pregnancies (Finer and Zolna 2016, Table 2).

Is this difference between poor and wealthier women's use of abortion a result of poor women facing insurmountable obstacles to accessing abortion care? Is some or all of it attributable to differences in values regarding abortion between women in different income groups? Or given the fact that "unintended" is not synonymous with "unwanted," is some of it attributable differences in preferences around the timing of childbearing (Aiken et al. 2015; 2016)? For example, perhaps some low-income women with unintended pregnancies have less reason to think their parenting circumstances will be better later with a "planned" pregnancy than they are now given facts such as long-term structural poverty or the high rate of incarceration of men of color (Edin and Kefalas 2011).

To answer these questions, I propose an ethical natural experiment: repeal the Hyde Amendment.

The Hyde Amendment has barred the federal insurance program for indigent people, Medicaid, from covering abortion care except in cases of rape, incest, or life-endangerment since 1977. As Congressman Hyde said at the time, "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. Unfortunately, the only vehicle available is the … Medicaid bill" (Hyde 1977). Congress has similarly restricted abortion coverage for other women who rely on the federal government for insurance coverage, including those covered by the Indian Health Service (Boonstra 2007).

The Hyde Amendment and its state copycats unethically rob women of autonomy based on income. Excluding abortion from insurance that covers childbearing allows strangers who believe abortion is immoral, or who want women to stay in traditional family roles, to try to do with economic coercion what they couldn't do with persuasion—stop indigent women who want to end their unwanted pregnancy with a safe, legal medical procedure they think is morally acceptable. And it works: One study asked Louisiana women presenting for their first prenatal care visit if they considered abortion, and those who said yes and were insured by Medicaid were asked whether Medicaid not paying for abortion was a reason they had not had an abortion. These numbers led the researchers to conclude that approximately 3,000 Louisiana women with Medicaid give birth per year instead of having an abortion because Medicaid does not cover abortion, and that if Medicaid covered abortion, 14% rather than 10% of Louisiana pregnancies would end in abortion (Roberts et al. 2019). Other poor women obtain the abortion they wanted, but the time it takes them to save or borrow the money to pay for it pushes them from a first trimester to a second trimester procedure, which increases medical risk, cost, and often travel time to obtain (Blanchard et al. 2017; Finer et al. 2006; Janiak et al. 2014). This governmental policy of forced childbearing and forced delay of medical care for the poor also has a racially discriminatory impact, since 31% of Black women and 27% of Hispanic women aged 15–44 were enrolled in Medicaid, compared with 16% of white women in 2018 (Guttmacher Institute 2020).

[2]It is important to note that some women talking about race, poverty, and abortion are community advocates who do not publish in the indexed literature. I use PubMed to make this point because it is likely representative of what AJOB readers publish and read, and I am speaking to a potential gap in our field's collective work. (PubMed contains publications from approximately 7,000 journals related to biomedicine and health, and "[h]ealth sciences practitioners, researchers, faculty, and students have repeatedly reported PubMed and MEDLINE as one of the few sources they use to search literature."; Williamson and Minter 2019)

Therefore, bioethicists concerned with health disparities should actively support passage of Congressional legislation that would repeal the Hyde Amendment ("The Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act"), and those of us living in one of the 33 states with a parallel version of the Hyde Amendment in our state's Medicaid programs should participate in efforts to expand state-level coverage as well (Guttmacher Institute 2016; All Above All n.d.; American Civil Liberties Union 2019). For similar reasons, bioethicists should oppose restrictions that impose unnecessary additional expenses for travel, missed work, and (for the 59% of abortion patients who are already mothers) childcare, such as waiting periods and bans on telemedicine for medication abortion (Jerman et al. 2016).

This is a moment of particular receptivity to health disparities analyses, and the fact the need for abortion care is so rarely framed as a health disparity reeks of abortion exceptionalism. The disparities framework encompasses a wide range of health issues, and including abortion access in this range could help normalize a medical intervention 1 in 4 U.S. women will need in their lifetime.

DISADVANTAGES OF APPLYING THE HEALTH DISPARITY FRAMEWORK TO ABORTION CARE

The goal of family physician Christine Dehlendorf and coauthors in applying the health disparities framing to abortion care was to underscore the health and economic harm of birth from unintended pregnancy to mothers and children (2010), to expand the public health conversation from an exclusive focus on prevention of unwanted pregnancy to the treatment strategy of increasing access to abortion care (2011), and to refute claims that these statistics are evidence of racism and coercion among those who provide abortion care by illuminating the economic and social forces that underlie the numbers (2013). However, they do not explicitly analyze the disadvantages of the health disparities framing, which I add here.

First is the risk that actively associating abortion with a disproportionate representation of Black and Hispanic patients, as opposed to the more common "all women have abortions" mantra, directs racialized abortion stigma to these populations generally.

Second is the risk that it could contribute to the racialization of poverty in inaccurate ways that affirm damaging stereotypes. In 2014, 62% of abortion patients were women of color, and 75% were poor or low-income. It is tempting to collapse these numbers and talk about the need for abortion care among "low income women of color," but equating poverty with people of color insidiously advances a tale of white economic superiority, as if all white people are middle and high income. Some of the approximately 574,244 women of color who had an induced abortion in 2014 were middle class or wealthy, and some of the approximately 694,650 poor and low-income women who had an induced abortion in 2014 were white, but the 2014 Guttmacher analyses do not identify racial groups within the category of poor patients, or income groups within the categories of racial groups (Jerman et al. 2016). As noted earlier, Black and Hispanic people are disproportionately poor, and it is important to address the intersectional burdens and barriers this dual identity imposes as compared to white people who are poor, or Black and Hispanic people who are wealthy. Yet it is also true that in 2019 the number of poor white people in the U.S. was approximately the same as the number of poor Black and Hispanic people combined (Kaiser Family Foundation 2019).

Third, regardless of their actual import, these data could be misused to fuel false racist claims about sexual promiscuity, "irresponsible" procreation among women of color, or false claims about abortion providers being racially predatory (Stone and Shannon 2022; Guttmacher 2014). Another relevant article that comes up in a PubMed search of "abortion and disparit*" is an example of misappropriation of these data. In 2020 authors affiliated with an Institute dedicated to overcoming the "scourge" of abortion used the difference between Black and white abortion rates to assert that "there may be no better metric for the value of black lives" (Studnicki et al. 2020). This perverse hijacking of the "Black Lives Matter" concept implies that Black abortion patients view their embryos or fetuses as "people," and they have abortions because they don't value other Black people.

Law professor Michelle Oberman published an article in the ethics literature focusing on abortion patient poverty that is relevant to this conversation, although she doesn't explicitly use a health disparities lens (Oberman 2018). Distracting debates triggered by false race-based claims are one reason Oberman encourages us to shift (or at minimum, expand) our gaze from race to abortion patient poverty. Her illumination of how expensive and difficult it is to have a child in the U.S. is critical, and she's absolutely right that for many people, abortion "is not so much a choice as a response to the ways in which poverty

inscribes itself onto our bodies" (Oberman 2018). But I worry that ignoring the ways the intersectional identities and experiences of poor women of color are different than poor white women's encourages a different type of analytic harm in which white scholars and policy makers mistakenly overlook the roles historical legacies and structural racism play in the reproductive decision-making of women of color across the income spectrum. In addition, silence about race and abortion arguably creates uncontested space for abortion opponents to twist this data to suit their own narrative, as illustrated above.

Fourth is the possibility that focusing on low-income women's need for abortion could lead the middle-class and rich women who devote their personal and financial capital to keeping abortion legal to believe abortion isn't really their group's problem. In my book I wrote that when I told my medical students that one in three (and after rates dropped, one in four) women had an abortion, they couldn't believe it. At the time I attributed our collective surprise to the silencing power of stigma, and I still believe that is largely true. It was also a function of their youth, since every year of their reproductive lives would present more opportunities for accidental pregnancy. However, it was only when I got deeper into the data discussed in this article that I realized I had overlooked our demographics—Black and Latinx students are underrepresented in medical schools, as are students who grew up in lower-income families, compared to white, Asian, and higher income students. So if we sampled only my students' (and my own) social circles, our abortion rate would likely be less than 1 in 4.

I do not want to overstate this point, and in future work I hope to explore the difference between what I think of as "college poor" and structural poverty. I'm intrigued by the fact that 46% of abortion patients are 24 years old or younger (Jerman et al. 2016), and I wonder if and when the disparity framing inappropriately makes poverty an identity rather than a circumstance. For example, Cindi Leive is a wealthy white publishing mogul who wrote about having an abortion when she was a college freshman, and if she had been surveyed in a clinic waiting room it might have been accurate for her to report her income as zero (Leive 2018). Leive's story is consistent with the liberatory white feminist story of abortion removing an obstacle to their upward mobility in finances, family, and happiness. That archetype remains accurate for a large group that includes women of all races, but for women trapped in structural poverty, abortion allows them to prevent bad circumstances from becoming even worse. Much more than abortion rights are needed for the narratives of these women to merge with upward mobility stories, and the failure to account for these multiple realities has been a powerful critique of the white feminist movement in support of abortion rights.

Finally, my biggest concern about applying the health disparities framework to abortion care is my belief that the Reproductive Justice (RJ) framework, which was developed in the 1990s by women of color, provides an intellectually superior alternative. RJ identifies three equally pressing reproductive needs that women in historically marginalized groups have been denied: the right to *not* have children, the right *to* have children, and the right to parent the children one has with dignity and in safety[3] (Ross and Solinger 2017; SisterSong Women of Color Reproductive Justice Collective n. d.; Gilliam and Roberts 2021). This contrasts with the traditional white feminist understanding of "reproductive rights" as synonymous with "contraception and abortion" because historically their right to have children and to parent the children they have has not been threatened. The RJ framework positions reproductive control as a human right and asserts an entitlement to governmental assistance, which by definition includes equal Medicaid coverage for having and not having a baby. Rather than comparing women of color to white women, RJ puts the unique histories, life experiences, and needs of women of color (and other historically marginalized groups, such as queer women and women with disabilities) at the center of the analysis.

This perspective is crucial in discussion of unintended pregnancy because the reason poor women are overrepresented among abortion patients is not just the difficulty of affording a (or another) baby. Poor women also have five times more unintended pregnancies than women with incomes above 200% of the poverty line—112 per 1,000 versus 20 per 1,000. Framed as a percentage of all pregnancies, in 2011 60% of pregnancies were unintended in women with incomes below the FPL; 52% of pregnancies were unintended in women with incomes at 100–199% of the FPL; and 30% of pregnancies were unintended in women with incomes at 200+% of the FPL (Finer and Zolna 2016, Tables 1 and 2).

Black women with incomes above the poverty line still have approximately twice the rate of unintended pregnancy of white and Hispanic women of the same

[3]Twenty years after this definition of RJ was established, a fourth pillar of sexual autonomy and gender freedom was added.

income (Finer and Zolna 2016, Figure 2). An analysis of 2011 data that combined race and income level found all women under the FPL had high unintended pregnancy rates, but the rate for Black and Hispanic women was higher than the rate for white women. The rate drops for all racial groups at income levels of 100% and 200% of the FPL, but it drops more dramatically for Hispanic women (Finer and Zolna 2016, Figure 2).

Perhaps this is why Guttmacher researchers who analyzed the relationship between race and income in their 2008 abortion patient data set concluded that "[r]egardless of poverty group, African American women had the highest abortion rates, followed by Hispanic women and then white women. … These patterns suggest that poverty alone does not explain the higher abortion rates among minority women" (Jones and Kavanaugh 2011). A 2011 analysis by racial group that did not separate income status reports that the percent of all unintended pregnancies that people chose to end in abortion was 50% for Black women, 40% for Hispanic women, and 36% for white women (Finer and Zolna 2016, Table 2).

Higher income does not eliminate racial disparity in other health domains such as maternal mortality, and data on unintended pregnancy might be additional evidence that racism is a barrier to health across income levels (Petersen et al. 2019; Troutman et al. 2020). Or it may show, in part or in whole, something about the values and preferences of Black women about prevention versus treatment of unintended pregnancy.

Disparities analyses often have the goal of bringing everyone to the health standard of the most economically and socially privileged group in a society (Braveman, 2006). If the health disparity is defined as unintended pregnancy, this metric would define the public health goal as reducing every group's unintended pregnancy rate to under 20% rates of higher-income white and Hispanic women (Finer and Zolna 2016, Figure 2). But what if a woman's knowledge, experience, and fear of medical racism and institutional reproductive control means the idea of taking the abortion pill to trigger an early miscarriage at home feels better to her than the idea of allowing a doctor to insert an IUD that only another doctor can take out? Distrust is a factor in racial disparities in contraceptive use (Haider et al. 2013; Randall 1996; Thorburn and Bogart 2005). For example, in one study Black and Hispanic women were more likely than white women to rank factors associated with less effective contraceptives (such as "I can get it without seeing a doctor or going to a clinic" and "I can stop using the birth control method anytime") as an "extremely important" feature of contraceptive method choice (Jackson et al. 2016).

Additional research is needed to identify how much of the racial difference in unintended pregnancy is attributable to factors such as differential access to effective contraception, education, and the interpersonal power to refuse unprotected sex, and how much of it is attributable to racism—preferences inspired by historical traumas such as forced reproduction during enslavement, forced sterilization intended to limit the reproduction of Black, Latinx, and Native American women, and racially discriminatory medical experimentation (Randall 1996; Gilliam and Roberts 2021; Roberts 1997; Stern 2005; Theobald 2019; Washington 2008). All women of color deserve the option of respectful, culturally sensitive, and easily accessible contraceptive care, and the field of family planning should continue its work in that direction. However, after a woman has an unwanted pregnancy it is too late for prevention, and we must shift focus to treatment. If some of Black and Hispanic women's higher unintended pregnancy rate is attributable to a historically grounded avoidance of physicians or family planning clinicians, then policies that insist on a prevention focus for unwanted pregnancy and exclude a treatment focus are just a new chapter in the old history of racist legal and social control of Black and Hispanic women's bodies and reproductive destinies. In addition, family planning polices that seek racial and/or economic parity in unintended pregnancy rates, but not in abortion rates after unintended pregnancy, have missed half the analysis.

CONCLUSION

Leaders in general medical and policy circles will need to be activated to improve the post-*Roe* landscape, and many of them know and accept the disparities framework. The fact that advocacy is more likely to be successful when it begins with a mental model the decisionmaker already holds and "the ask" is to fill a gap, rather than to learn and accept a new model, is an argument in favor of situating the need for abortion access within the disparities framework. However, whether justice requires those advocating for abortion access within these circles to take the potentially slower route of educating and advocating toward the robust RJ framework is a strategic issue that deserves debate. The immediate answer may lie in an academic version of code switching. We must become fluent in

the languages and imperatives of both health disparity and RJ justifications for removing barriers to abortion care and switch between them depending on who we are talking to, with the long-term goal of making the RJ framing as familiar and persuasive in general medical and policy circles as it has become in reproductive and advocacy circles.

Things are about to get worse for people capable of pregnancy in the United States, as well as the clinicians who care for them. Poor women, Black and Hispanic women, and all other people confronting unwanted pregnancy need the intellectual, social, and political capital of AJOB readers to help them get the medical care they need. Applying the familiar health disparity lens to abortion care could be a path out of abortion exceptionalism that would help us make a justice argument for preserving or expanding access to safe abortion within our institutions and communities, and for changes to state and federal Medicaid policy that would expand timely access. My hope is that using a framework that has long been applied across medicine and that brings a structural focus might give scholars, educators, clinicians, and administrators who are nervous about the topic's toxic politics a more accessible banner under which they can join others in naming our country's unjust disparity in the need for abortion care and working to eliminate barriers to access.

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