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THE HYDE AMENDMENT: ITS IMPACT ON LOW
INCOME WOMEN WITH UNWANTED PREGNANCIES

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ABSTRACT

The Hyde amendment, which has been in effect since 1977, restricts federal funding of abortions for Medicaid-eligible women "except where the life of the mother would be endangered if a fetus were carried to term." It has virtually eliminated federally financed abortions and the undue hardships it places on poor women foreshadow contemporary developments in abortion politics today for all women.

INTRODUCTION

In the 1973 landmark case of Roe v. Wade, the United States Supreme Court guaranteed a woman's right to choose abortion. But the High Court decision left the abortion issue far from settled. Since that time the courts and legislatures have been engaged in countless judicial and legislative battles between the "pro-choice" forces and the liberal philosophy they represent on the one hand, and the anti-abortion forces and New Right conservatism on the other. The anti-choice philosophy of the "right-to-life" movement has been summed up by spokesperson Louise DeVoto, who said, "in every woman there is a force that wants to reproduce, to fulfill womanhood. It makes it easier if you don't have a choice."

In the Fall of 1982 the Supreme Court will hear five appeals involving laws in Missouri, Virginia, and Akron, Ohio. It will rule on the constitutionality of abortion restrictions ranging from parental consent for minors to hospitalization requirements for second-trimester abortions to 24-hour waiting periods. The 1978 "Akron Ordinance" was designed to serve as a national model for local regulation of abortion, and, among other things, required a physician performing an abortion to "counsel" the patient by informing her that the procedure "can result in severe emotional disturbances" and by telling her that "the unborn child is a human life from the moment of conception."

Even if these restrictions are upheld, however, none of these cases would allow the court to overturn the 1973 Roe v. Wade decision. A woman's right to terminate a pregnancy in the first and second trimesters would still be guaranteed by the Constitution. This is the fundamental premise which the anti-abortion movement wants Congress to reconsider.

The Hatch amendment (S.J. Res. 110), sponsored by Senator Orrin Hatch of Utah, has gotten further than any other proposed constitutional amendment to prohibit abortion. It holds that "the right to abortion is not secured by this Constitution," and allows that either a state or Congress has the right to "restrict or prohibit abortions": the stricter law would have to be obeyed. A "states rights" version of the Hatch amendment would leave the abortion question entirely up to the states.

For many abortion foes, the Hatch amendment is unacceptable because it does not go far enough. Senator Jesse Helms' "Human Life Statute" (S. 1741) gives legal personhood status to a fetus from the moment of conception, thereby outlawing abortion and some forms of birth control. The most extreme anti-abortion groups are supporting this bill as a strong interim step toward the ultimate goal--a "Human Life Amendment" to the Constitution.

Senator Mark Hatfield has introduced a bill (S. 2372) which would prohibit funding not only for abortion, but for abortion referral, training in abortion techniques, and federal insurance coverage for abortion. It also provides for direct appeal to the U.S. Supreme Court from a district court ruling on any state law enacted on the basis of this act. He refers to this bill as providing a "fall-back position" if the Senate fails to approve the Hatch amendment.

We already have one major piece of anti-abortion legislation, which has been in effect since 1977--the Hyde Amendment. Examining its effects may be important for making political judgments about the even more restrictive Hatch, Helms, and Hatfield proposals described above. The amendment's author, Rep. Henry Hyde of Illinois, is also the House sponsor of the Helms and Hatfield bills. In this paper I will describe the Hyde amendment and its observed and potential effects on poor women, including illegal abortion, dangerous delays while funding is obtained, and unwanted births. The undue hardships it places on poor women foreshadow the potential effects of the contemporary developments in abortion politics.

THE HYDE AMENDMENT

The Hyde amendment has been a rider to the Labor-HHS appropriations bill since 1977, and is voted upon each year by Congress. It

primarily affects the Medicaid program (Title XIX of the Social Security Act), which uses combined state and federal funds to pay the costs of medical care for indigent people. The Hyde amendment states that no federal funds shall be used to perform abortions except where the life of the mother would be endangered if a fetus were carried to term. In 1978 Congress restored federal funding of abortions "for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or in those instances where severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term, when so determined by two physicians." All restrictions were lifted temporarily in 1980, when a United States District Court ruled that to deny Medicaid funds to poor women was unconstitutional (McRae v. Harris). The McRae suit was brought on behalf of Cora McRae, who was denied a Medicaid abortion in 1976, and was continued as a nation-wide class-action suit on behalf of all women needing Medicaid-funded abortions. Federal funding for abortions resumed for seven months, until it was again restricted when the Supreme Court, on June 30, 1980, upheld the constitutionality of the Hyde amendment. Currently no federal funding of legal abortion is allowed except to save the life of the pregnant woman (Cates, 1981).

Since the Supreme Court decision went into effect in September, 1980, only nine states (Alaska, Colorado, Hawaii, Maryland, Michigan, New York, North Carolina, Oregon and Washington) and the District of Columbia have continued to voluntarily pay for medically necessary abortions out of state and county funds in the absence of federal aid (Jaffe, 1981); two states are currently under court order to fund Medicaid abortions. Thirty-nine states, which performed 70 percent of all Medicaid abortions in 1977, cut off Medicaid payments. Eighteen states adopted the Hyde language, and will pay only in cases of rape, incest, or the determination of two physicians; sixteen states will pay only in life-endangering situations. Whatever the restricting language used, the number of abortions paid for by Medicaid was reduced by 99 percent following the passage of restrictive legislation (Alan Guttmacher Institute, 1979; Jaffe, 1981). Eighty percent of the abortions now funded under Medicaid are to preserve the woman's life. Department of Health and Human Services data indicate that if all states enact the language of the Hyde amendment, the total number of abortions for the poor will decline by 70 percent, to less than 3,000 annually. In fiscal year 1977, the year before funding restrictions, one quarter of all abortions for the poor were paid for by Medicaid (AGI, 1979; Lincoln et al., 1977).

The Hyde amendment presents women on Medicaid faced with an unwanted pregnancy with an unmet need for abortion, resulting in 1) a return to illegal abortion, 2) dangerous delays while they obtain funding, or 3) unwanted births. Since Medicaid does fund sterilization,

the legislation might also affect birth control and sterilization choices. For example, women not eligible for Medicaid abortions might avoid pregnancy by avoiding exposure to it through "voluntary" sterilization. That this might not otherwise have been the birth control choice may in some ways constitute sterilization abuse (Handschu et al., 1979).

Who are the affected women? Nine percent of all women in the United States of reproductive years are poor enough to be eligible for Medicaid. Of these women, 57 percent are at risk of incurring an unintended pregnancy. Most of these women are young, white (52 percent), and have only some high school education. Most families receiving Aid to Families with Dependent Children (AFDC) and Medicaid are new to welfare, and most of the dependencies are caused by a crisis. The families tend to be small and young (AGI, 1979).

ILLEGAL ABORTION

Abortion is not a new phenomenon. Prior to its legalization women had exercised the option of terminating unwanted pregnancies at the rate of approximately 1,000,000 per year (AGI, 1979). It was estimated that in New York City alone, 50,000 illegal abortions were performed annually (Polgar and Fried, 1976). Studies on illegal abortions (Bose, 1979; Cates and RoCHAT, 1976; Polgar and Fried, 1976) reveal that 80 percent of the women attempted to self-induce by oral ingestion, insertion of something into the uterus, or douche; only two percent involved a physician and the remainder involved ordinary "lay" women. Legalization of abortion in New York in 1970 resulted in a sharp drop in abortion-related deaths in New York compared to states with restrictive laws, and maternal deaths declined more sharply in New York than in other states as a result of abortion legislation. In addition, the data from New York City hospitals (voluntary and municipal) show a sharp drop in abortion-related admissions following legalization (AGI, 1980). Soon after liberalization of abortion laws in the United States, reports of declines in newborns relinquished for adoption and rates of births to unmarried mothers occurred (Berger, 1978; AGI, 1980). Following legalization, safe and legal abortions replaced clandestine procedures. Without funding, there is an increased risk that more poor, pregnant women would resort to these dangerous alternatives.

The consequences of a restrictive abortion law in Rumania in 1966 following many years during which abortion was legal and widely used as the main method of birth control were studied by Teitelbaum (1972), Wright (1975), and Berelson (1979). The most immediate results were a rapid and large increase in the birth rate, and in the rates of morbidity and mortality among women who had clandestine abortions. The situation in the United States differs in that only pub-

licly-funded abortions are affected, and that abortion is used here primarily as a back-up method for contraceptive failure. These studies are significant in anticipating higher morbidity rates among these American women, due either to delay in obtaining private funding for abortion, or to delay in obtaining the determination by two physicians of "severe and long lasting health damage." There is also some confusion among physicians as to what constitutes "severe" or "long lasting."

DANGEROUS DELAYS

The literature abounds with studies indicating that for unwanted pregnancies, abortion in the first trimester is the safest option available to women, and that denial of public monies for legal abortion will result in an excess of maternal death no matter what alternative is chosen (Petitti and Cates, 1977; Cates and Tietze, 1978; AGI, 1980). While Medicaid abortions account for 25 percent of all abortions, they are associated with 35 percent of all abortion-related deaths (Bracken, 1978; Lincoln et al., 1977). Risk of death increased with gestational age, and restriction of public funds was found to be significantly associated with a later gestational age at the time of the abortion (DHEW, 1979; AGI, 1980). Mortality in pregnancy and childbirth is greater than that in legal abortion regardless of age or race, and delays in obtaining legal abortion (while the woman attempts to raise money or to convince two doctors that she will suffer severe and long lasting health damage) may mean exposure to increased risks of death associated with advancing gestational age (DHHS, 1980). There is a 50-fold difference between abortions performed before nine weeks gestation and those performed at 16 weeks or later (Berger, 1978).

Early abortion is an extremely safe medical procedure, but each week of delay increases the risk of medical complications by 20 percent and the risk of death by 50 percent (AGI, 1979). First trimester abortion is 12 times safer than childbirth, and if it is performed in the first eight weeks of gestation it is 25 times safer (Cates, 1977; Cates and Tietze, 1978). In states where Medicaid cut-off has occurred, Medicaid women get abortions one to two weeks later than affluent women, while there is no apparent change in the gestational period at which abortion is obtained in states which continue to fund abortions (AGI, 1979). In clinics which partially subsidized abortions, women's own personal funds made up the difference between the subsidy and the full cost of the procedure (Rubin, 1979).

UNWANTED BIRTHS

Unwanted births are another outcome of restricted abortion. In 1972 there were 800,000 of these unwanted births (Schwartz, 1972).

A study by Trussel et al. (1980) attempted to estimate the minimum number of pregnant Medicaid-eligible women who would have obtained abortions in the absence of the Hyde amendment and to compare this figure with the actual number of recipients. It was determined that approximately 20 percent of the women who were unable to obtain Medicaid-funded abortions carried their unwanted pregnancies to term. A recent report from the Center for Disease Control (CDC) estimates that five percent of the Medicaid-eligible pregnant women carried their pregnancies to term. The estimated 9,000 women who continued to term were primarily teenagers, probably because they were the most likely to delay their decision until the second trimester of pregnancy when abortion is less available and more expensive than abortions obtained in the first trimester of pregnancy (Cates, 1981).

Unwanted children, and children born to women denied abortion were more likely to be brought up in poverty, to be physically and emotionally abused, to suffer from malnutrition and to have their education limited. They were also more likely to spend their formative years without a father in the home and to show signs of emotional disturbance, learning and behavioral problems when they reached school age (Dytrych et al., 1975). Babies born to teenagers (a high percentage of unwanted births) were more likely to be premature or low birth weight than infants born to older mothers. Low birth weight in turn is a major cause of infant mortality and other childhood illnesses and birth defects (AGI, 1979). The incidence of post-partum psychosis is much higher than that of post-abortion psychosis (Brewer, 1977). Unwanted pregnancies tend to deepen poverty and lengthen dependency (AGI, 1979).

FUNDING

The cost and benefits of the New York City experience indicate that limitation of public funding for abortion leads to increased health care costs because the alternatives of childbirth or complications from childbirth, hospitalization of low birth weight infants and women with complications from illegal abortions, and support for additional and larger families by AFDC and foster care may far exceed previous expenditures for abortions (Robinson, 1974; AGI, 1980). The actual impact of non-funding on the number of excess abortion deaths would depend on the number of women seeking medical funds for abortion, on the proportion choosing to carry to term, on those choosing illegal abortion, and on the delay encountered in obtaining other funding sources (Petitti and Cates, 1977). As public funds are restricted, 5-90 annual excess deaths were estimated to result for women of childbearing age in the United States, depending on what options were chosen. The incidence of hospitalization of Medicaid-eligible women with abortion-related complications was greater after August, 1977 than it was in the earlier period (J. Gold et al., 1980) and the CDC,

which monitored the effects of the cutoff, linked four deaths of indigent women between August 1977 and February 1979 to the unavailability of Medicaid financing (J. Gold and Cates, 1979).

Even before the funding cutoff, when the number of abortions funded under the Medicaid program had been increasing, the unmet need for abortion services was still disproportionately high among Medicaid-eligible, poor, rural, non-white and teenage women (AGI, 1979; Jaffe et al., 1981; Lincoln et al., 1977). The Hyde amendment has reversed a trend of slowly narrowing the gap between need and service provision.

Although public attitude favors legal abortion (Granberg and Granberg, 1980), in fiscal year 1977 one third of pregnant Medicaid-eligible women who desired abortions were unable to obtain them (R. Gold, 1980). With restrictive legislation, the unmet need of women on welfare who want and need abortion services but who cannot get help from federal or state government is expected to triple. The unmet need for publicly-funded abortion services among Medicaid-eligible women can be expected to rise from 31 percent to 79 percent, and these women can be expected to increase their proportion of the overall unmet need for abortion services from 23 percent to 44 percent unless they can pay for their own abortions without government subsidy (AGI, 1979).

There was a relatively high rate of abortions among poor women during the year before enforcement of the Hyde amendment, despite their high level of contraceptive use. Contraceptive use increased among women in poverty following abortion legalization, which contradicts the notion that poor women get pregnant out of wedlock in order to receive welfare payments. Abortion rates of poor women are higher because they have more unwanted pregnancies (AGI, 1979).

Cates (1981) argues that the Hyde amendment has had a more profound effect on the funding source than on the number of abortions obtained by Medicaid-eligible women. He found that 94 percent of the 180,000 Medicaid-eligible women with unwanted pregnancies obtained a legal abortion; only five percent carried their pregnancies to term, and only an estimated one percent resorted to illegal abortion. He concludes that although the Hyde amendment has been effective in nearly eliminating federally-financed abortions and in shifting the payment source for about one third of abortions from the public to the private sector, it has had only a minor impact on the number of abortions obtained by Medicaid-eligible women who wanted to terminate their pregnancies. And what "private sector" means here is not the vast assets of large corporations, but the meager resources of women at the bottom of the economic scale.

CONCLUSION

The major hope of the Hyde amendment's supporters was that it would decrease abortions. The major fear of those opposed to it was that it would deny equal access to quality medical care for all women regardless of socio-economic status. If Cates is right, the effect of this amendment has not been the intended one of decreasing abortion, but rather the unintended and unfair one of adding to the hardships of poor women. If any of the Hatch, Helms, or Hatfield proposals succeed, we can expect to see greater economic burdens placed on middle- and upper-class women because of illegal abortions (and travel expenses to those places where abortions are legal or available). In addition, these women may face the prospects of dangerous delays (while funding or illegal abortionists are sought), or of unwanted births. These women, who now enjoy relatively easy access to legal abortion, would then begin to share some of the unfair burdens and humiliations to which the Hyde amendment now subjects poor women.

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