

Lessons from the Front: Abortion and the Battle for Health Care Access

Eesha Pandit

Editors' Note: In the battle for health care reform this past fall the rights to safe, accessible abortion and bodily integrity were among the first casualties. Eesha Pandit looks at the legacy of the Hyde Amendment and the role of the privacy doctrine of *Roe v. Wade* in this development. She proposes a way forward, not only for political organizing but for thinking about how to reframe the right to abortion and health care.

— Betsy Hartmann and Ellen Gattozzi, co-editors for this issue.

In the US Congress, there are bills and there are Bills. There are those bills that pass swiftly, though admittedly there are fewer and fewer of this sort. Then again, there are the Herculean efforts that take the work of subcommittees and commissions and a patchwork of sworn ideologues to cross party lines. The effort at national health care reform is this sort of Herculean effort that has been a long time coming, and continues on even today. Women's reproductive health is, as expected, a lightning-rod issue in the reform debates. The questions for reproductive health activists were clear early on. How will health care reform affect access to reproductive health care? Will the legacy of the 1976 Hyde Amendment persist and ensure that any public program expansion will not

include abortion coverage? Or will we be able to utilize the opportunity for reform to make some much needed change in our national policy?

Anyone who followed the reform effort knows the answers to these questions. Health reform, even at the early stage of Congressional subcommittee debate, became a vehicle for anti-choice legislators to draw lines in the sand. It enabled them to hold the entire bill hostage to their demands to restrict abortion coverage far beyond the restrictions already imposed by the status quo.

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What, then, is the status quo on abortion coverage? The current restrictions on funding—most notably the Hyde Amendment that bars federal Medicaid funding from paying for most abortions — currently create a two-tier system of abortion access for poor women who receive public health care and those who have private health insurance. As it stands, almost 90% of private insurance plans include abortion coverage. Current restrictions on federal funding are based on the theory that the state is not obligated to provide funds for abortions, even though it has acknowledged that women have a right to seek and have them. In addition to women who get their health coverage through Medicaid, abortion coverage bans also apply to federal employees, women or spouses of men in the military, disabled women, and women who receive health care through Indian Health Services. Before the Hyde Amendment, women could access abortion services regardless of their income because Medicaid covered abortion care like it did every other medical service. However, since 1976, low-income women's ability to exercise their rights has been severely restricted.

Those are the present restrictions. What further restrictions were proposed via health reform legislation? In the form of amendments to the health care bills in the House and the Senate, further restrictions were imposed so that both houses of Congress could entice anti-choice democrats to support the bill. In the House bill, the Stupak-Pitts Amendment would ban coverage (except for cases of rape, incest or threat to the woman's life) in any plan in the national insurance exchange that has even one policy holder receiving a federal subsidy. Abortion coverage would only be available as a rider on the basic insurance policy. In the Senate bill, the Nelson Amendment would allow states to prohibit abortion coverage (except for cases of rape, incest or threat to the woman's life) in state insurance exchanges. Insurers would be required to segregate funds received for abortion coverage from other revenues to ensure no federal funds are used to pay for abortions. In other words, if abortion is part of the plan, there would be two separate premium payments for every person purchasing insurance — one small check for abortion coverage and one

much larger check for coverage that would include everything else.

This situation exemplifies how the Hyde Amendment haunts us to this day. As we determine access to health care, the legacy of the Hyde amendment has made it politically impossible to cover abortion care in health care reform. And this is where history meets the present day.

What is the Legacy of Hyde?

Admittedly, Congressman Hyde was looking for a way to stop all women from getting any abortions at all. At a Congressional hearing on Medicaid in 1997, he said, "I would certainly 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."¹ But because of *Roe v. Wade* he couldn't do that; the best he could do was to attach an abortion restriction on funding via the appropriations bill that passes every year. Too often considered a political infeasibility, overturning the Hyde Amendment should be one of the topmost organizing goals of the reproductive justice movement. Without this, we will remain unable to gain the traction we need to enact policy changes that make abortion care accessible to poor women and women of color around the country.

The legacy of the Hyde Amendment has brought us to the place of arguing down from the status quo, not up. Ignoring the needs of women of color and low income women is not merely bad politics, it is terrible progressive policy. This course was charted in 1976 when the Hyde Amendment became the law of the land. When our President spoke to a joint session of Congress this past September and promised us all that no federal dollars would support abortion coverage, it is the legacy of Hyde that emboldened him. When our representatives looked us in eye and said there was nothing they could do to overturn 33 years of precedent of the federal funding ban, this, too, was the legacy of Hyde.

This brings us to another, broader point about how the right to an abortion is defined in the

US. The Supreme Court's landmark 1973 *Roe v. Wade* decision legalized abortion on the grounds of women's right to privacy, not as an essential component of the right to health care and bodily integrity. The Supreme Court's decision to define the right to an abortion in the arena of privacy, and not in the arena of health care, is what enabled Congressman Hyde to make the case that abortion was not a right that the government is required to secure for women. Privacy is a negative right, a right that depends on freedom from government interference. It is not a positive right, the kind of right that the government is obligated to secure for us. Health care is a positive right. Abortion, then, is not a right that our government is required to secure for us. As is the case with most negative rights, this one leaves those most vulnerable in our society without any recourse. It leaves poor women dependent on the government to provide them with health care at the mercy of our political process.

What are the lessons we can draw from this unfortunate legacy? There are two moral realities that we must confront if we are to change the status quo and prevent further roll-backs of our rights.

First, our political system does not concede that reproductive health and abortion are part of health care. Think back to the last presidential election. When asked about abortion, Republican candidate McCain used scare quotes when referencing the need for an abortion as being necessary to secure a woman's "health." He stated, "Just again, the example of the eloquence of Sen. Obama. He's health for the mother. You know, that's been stretched by the pro-abortion movement in America to mean almost anything. That's the extreme pro-abortion position, quote, 'health.'"² Until, we are able to consistently describe and situate access to abortion as a part of just and comprehensive health care services, we will fight the same fights over and over again.

Second, another moral disjuncture surfaces regarding policies that would enable poor women, and poor people in general, to attain access to the same health care that non-poor people do. When progressive legislators propose such legislation,

they face extreme opposition by those that equate wealth with increased rights. We are seeing this with health care reform. Battles have ensued over how much to expand Medicaid (if at all) and over providing more resources to safety-net providers and other programs that are solely geared towards providing America's poor with health care coverage. When we constantly argue whether health care is something our government owes to vulnerable people in our society, we are engaged in this moral debate. Stemming from a racialized capitalism is the belief that some people deserve more than others because of who they are or how much money they have. When this type of thinking is applied to health care, the result is a profit-driven industry in which wealth literally serves as the difference between life and death, between choice and no choice, between justice and injustice.

The Way Forward

Where do we go now? Where from here, from this place of uncertainty about the health reform bills, from uncertainty about the strength of the progressive movement in the US? Many are offering prescriptions for success — I will not presume to do that. Instead, I offer a reminder that draws on the ideals of the progressive movement, and the words of one of its presumed leaders: "We lose ourselves when we compromise the very ideals that we fight to defend. And we honor those ideals by upholding them not when it's easy, but when it is hard."³

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Our president said those words upon receiving the Nobel Peace Prize. While it is not an international war that we face, it is certainly a battle. It is indeed hard as we are up against a Democratic majority that seems completely divested from a progressive

base and a conservative opposition that seems to be growing in intensity and political capital. I can only argue that we continue our work with re-invigorated hearts, to build and sustain a movement for progressive change. Community organizing will save us, as it always has. Great changes have been sparked by small efforts as they gathered momentum and

power. The abolition of slavery, women's equal rights, civil rights — these changes in American society were borne of action, not electoral math. It is that history that we must channel now, and steel the spine of our political tactics with the reinforcement of an invigorated and mobilized base of grassroots action.

About the Author

Eesha Pandit is currently Director of Advocacy at [Mergerwatch](#), a national organization that works to ensure patients' rights to comprehensive health care. She is active in MergerWatch's [Raising Women's Voices](#) initiative. Raising Women's Voices is a national initiative working to make sure women's voices are heard in the health reform debate and women's concerns are addressed by policymakers developing national and state health reform plans. She has formerly been a weekly staff writer for RH Reality Check. Recently, Eesha served as Associate Director of Programs at the [Civil Liberties and Public Policy Program](#), and has also worked with the Carr Center for Human Rights Policy at Harvard University and Amnesty International USA's Women's Rights Program. She is a graduate of Mount Holyoke College and the University of Chicago.

Notes

- 1 Emmens C. *The Abortion Controversy*. New York: Julian Messner, 1987. p. 68.
- 2 http://www.huffingtonpost.com/cecile-richards/mccain-says-womens-health_b_135205.html
- 3 http://www.huffingtonpost.com/2009/12/10/obama-nobel-peace-prize-a_n_386837.html