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ABORTION ACCESS IN THE GLOBAL MARKETPLACE*

MARTHA F. DAVIS**

In the United States, government funding of legal abortion for low-income women has been uniquely "de-linked" from the fundamental right to an abortion. While the underlying right to an abortion has been repeatedly reaffirmed, federal courts have been unreceptive to any imposition of an affirmative governmental obligation to fund the exercise of the right. In contrast, the human rights framework, increasingly adopted worldwide by other national and regional courts and legislatures, has supported expansion of government funding of legal abortion. The domestic U.S. treatment of abortion funding is illuminated by examining several recent transnational decisions—from Colombia, Mexico, and the European Court of Human Rights, among others—in which legal abortion, framed as a matter of human rights and human dignity, led to expansion of public funding. In particular, these examples indicate that in a context where a national public health plan was already in place, and where the provision of health care was already viewed as a government responsibility, the extension of health care coverage to include newly legal abortion procedures generated little controversy.

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** Professor, Northeastern University School of Law. Thanks are due to Ryan White, Jane Moisan, Richard Ratner, and Kyle Courtney for research assistance and Alicia Yamin for expert advice.

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INTRODUCTION

In recent years, pro-choice advocates in the United States have increasingly focused on women's right to abortion as part of a reproductive health care continuum, avoiding treating abortion as a discrete concern isolated from other issues of reproductive health. Notably, the National Abortion Rights Action League took the word "abortion" out of its name entirely, first changing its name to the National Abortion & Reproductive Rights Action League, then finally to the current, NARAL Pro-Choice America.[1] Indeed, NARAL's mission statement does not explicitly mention abortion, but states that NARAL's mission is "to support and protect, as a fundamental right and value, a woman's freedom to make personal decisions regarding the full range of reproductive choices . . . ."[2] Likewise, the Center for Reproductive Rights ("CRR"), that devotes significant resources to defending the right to abortion domestically and internationally, positions this work as part of a much broader agenda of reproductive rights and health advocacy. As CRR's mission states, "We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination."[3] Similar observations could be made about the American Civil Liberties Union's ("ACLU") Reproductive Freedom Project, Planned Parenthood, and most other U.S.-based pro-choice organizations that address abortion rights.[4]

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1. NARAL Pro-Choice America, Key Moments in NARAL Pro-Choice America's History, http://www.prochoiceamerica.org/about-us/learn-about-us/history.html (last visited Apr. 19, 2010).

2. NARAL Pro-Choice America, Mission Statements and Diversity Policy, http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/conclusion/mission-diversity.html (last visited Apr. 19, 2010).

3. Center for Reproductive Rights, About Us, http://reproductiverights.org/en/about-us (last visited Apr. 19, 2010).

4. According to the American Civil Liberties Union's ("ACLU") Web site, the "Reproductive Freedom Project protects everyone's right to make informed decisions free from government interference about whether and when to become a parent" and works

Domestic advocates might explain this approach by rightly pointing out that abortion is part of a closely intertwined bundle of reproductive health-related events ranging from conception to infertility to pregnancy to post partum care.[5] At the same time, there are strategic benefits to this "contextualizing" of abortion rights. For example, pro-choice advocates have become increasingly aware that the availability of abortion is an issue that often looms largest for white women.[6] Women of color, in contrast, have historically been in the position of defending their right to give birth while fending off others' efforts to deter their childbearing through abortion or other means, such as denial of welfare benefits, forced contraception, or even sterilization.[7] For example, in 1990, the *Philadelphia Inquirer* ran an editorial arguing that the then-controversial contraceptive Norplant should be used to "reduce the underclass."[8] Similarly, scholars have noted the role of racism in garnering support during the 1996 welfare reform debate for welfare benefit restrictions designed to discourage childbirth.[9] Sweeping the full range of reproductive rights into pro-choice advocacy efforts is an answer to charges that

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on issues of "reproductive health." American Civil Liberties Union, Reproductive Freedom, http://www.aclu.org/reproductiverights/index.html (last visited Apr. 19, 2010). Likewise, Planned Parenthood's Web site states that "Planned Parenthood has promoted a commonsense approach to women's health and well-being, based on respect for each individual's right to make informed, independent decisions about health, sex, and family planning." Planned Parenthood, Who We Are, http://www.plannedparenthood.org/about-us/who-we-are-4648.htm (last visited Apr. 19, 2010). While the Web site does list abortion as an offered service, it does not explicitly mention abortion rights or access within its advocacy goals. Instead, it states, "[W]e fight for commonsense policies that promote women's health, allow individuals to prevent unintended pregnancies through access to affordable contraception, and protect the health of young people by providing them with comprehensive sex education." *Id.*

5. *See, e.g.*, Symposium, *What to Expect: Legal Developments and Challenges in Reproductive Justice*, 15 CARDOZO J.L. & GENDER 503, 505 (2009) [hereinafter *What to Expect*] (including remarks by Lynn Paltrow, Executive Director of National Advocates for Pregnant Women, identifying a range of issues encompassed by "reproductive justice"); Julie F. Kay, Note, *If Men Could Get Pregnant: An Equal Protection Model for Federal Funding of Abortion Under a National Health Care Plan*, 60 BROOK. L. REV. 349, 398–99 (1994) (discussing a range of reproductive services that should be addressed under a proposed national health care plan).

6. *See* DOROTHY ROBERTS, KILLING THE BLACK BODY 101 (1997); Catherine Albiston, *Anti-Essentialism and the Work/Family Dilemma*, 20 BERKELEY J. GENDER L. & JUST. 30, 33–34 (2005).

7. Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1442–44 (1991).

8. Editorial, *Poverty and Norplant*, PHILA. INQUIRER, Dec. 12, 1990, at A18.

9. *See* MICHAEL J. CAMASSO, FAMILY CAPS, ABORTION, AND WOMEN OF COLOR: RESEARCH CONNECTION AND POLITICAL REJECTION 3–5 (2007).

women's rights activists are ignoring the real-life situations of a large group of women—women of color.

These reasons for embedding abortion within a larger reproductive health framework coexist with another strategic rationale: abortion is controversial in many parts of the world, among governments, institutions, and individuals.[10] Domestic advocates, many of whom also work internationally, may prefer to present their goals somewhat less controversially by framing their agenda as one involving women's health writ large.[11]

However, there are times when separating out abortion as a discrete event and a singular policy issue is appropriate and illuminating.[12] In training health care professionals, abortion is generally treated as a singular concept; there are several varieties of abortion, but when medical school training on abortion is provided, it typically addresses this collection of medical procedures as a single topic.[13] Because it is a specific type of procedure—and one that raises considerably more controversy than, for example, treatment of routine pregnancy—important insights may be gained by taking an independent look at abortion. Indeed, failure to explicitly name abortion as a specific issue may contribute to the fact that "abortion is far less often or completely studied than fertility, mortality, or contraception."[14]

This Article affirmatively "names abortion" by comparing domestic and international approaches to public funding of legal therapeutic abortion.[15] Interestingly, international legal norms often identify abortion as a human right that creates affirmative claims on the government, in clear tension with U.S. federal law that essentially

10. John C. Caldwell & Pat Caldwell, *Induced Abortion in a Changing World*, *Introduction* to THE SOCIOCULTURAL AND POLITICAL ASPECTS OF ABORTION: GLOBAL PERSPECTIVES 1, 1 (Alaka Malwade Basu ed., 2003).

11. *See, e.g.*, CTR. FOR REPROD. LAW & POLICY, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES; EAST CENTRAL EUROPE 10 (Mindy Jane Roseman ed., 2003).

12. *See What to Expect*, *supra* note 5, at 556 (indicating that panelists designated to speak on reproductive health conferred and decided to focus on abortion only, "which really is sort of back to the future").

13. ASS'N OF REPROD. HEALTH PROF'LS & MED. STUDENTS FOR CHOICE, A MEDICAL STUDENT'S GUIDE TO IMPROVING REPRODUCTIVE HEALTH CURRICULA 43 (2d ed. 2006), *available at* http://www.arhp.org/uploadDocs/medstudents_guide.pdf.

14. Caldwell & Caldwell, *supra* note 10, at 1.

15. The definition of "therapeutic abortion" is "[abortion] induced because of the mother's physical or mental health, or to prevent birth of a deformed child or a child resulting from rape." STEDMAN'S MEDICAL DICTIONARY 4 (27th ed. 2000).

posits abortion as a commodity, with access to the procedure regulated by the private market.[16] In the United States, funding of low-income women's access to abortion has been uniquely "de-linked" from the so-called "fundamental right" to an abortion.[17] In contrast, particularly in recent years, a human rights framework has been increasingly adopted worldwide by national and regional courts considering the issue of abortion, with government funding for legal abortions expanding alongside as a wider range of abortion procedures have become legal.[18] We can gain important insights about our domestic treatment of abortion by examining recent transnational decisions in which abortion was framed as a matter of human rights and human dignity and where, once legalized, public funding expanded to support access to the right.

This Article proceeds as follows: Part I discusses several aspects of the commodification of abortion, both nationally and internationally, contrasting the regime of markets with the regime of rights. Part II explores the international and comparative law of abortion, particularly focusing on recent transnational case law that denominates therapeutic abortion as a human right.[19] The Conclusion discusses the implications of this human rights approach and the challenges that it poses to the continued reliance on the market to

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16. *See*, *e.g.*, Martha F. Davis & Bethany Withers, *Reproductive Rights in the Legal Academy: A New Role for Transnational Law*, 59 J. LEGAL EDUC. 35, 44–50 (2009) (describing transnational norms and case law on the right to abortion); Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1933 (1987) (noting the danger that reproductive capabilities will become as commodified as other aspects of women's sexuality).

17. *See*, *e.g.*, Hyde Amendment, Omnibus Appropriations Act of 2009, Pub. L. No. 111-8, §§ 613–614, 123 Stat. 524, 676–77 (2009); *see also* K.A. Petersen, *The Public Funding of Abortion Services: Comparative Developments in the United States and Australia*, 33 INT'L & COMP. L.Q. 158, 171–80 (1984) (describing unsuccessful efforts to restrict public funding of legal abortions in Australia).

18. Since 1997, seventeen countries have liberalized abortion laws. Those countries are Benin, Bhutan, Cambodia, Chad, Colombia, Ethiopia, Guinea, Iran, Mali, Nepal, Niger, Portugal, Saint Lucia, Swaziland, Switzerland, Thailand, and Togo. GUTTMACHER INST., FACTS ON INDUCED ABORTION WORLDWIDE 1–2 (2009), *available at* http://www.guttmacher.org/pubs/fb_IAW.pdf; *see also* Rebecca J. Cook & Bernard M. Dickens, *Human Rights Dynamics of Abortion Law Reform*, 25 HUM. RTS. Q. 1, 6 (2003) (describing the expansion of abortion rights in many nations); Adrienne Fulco, *Secularization and Its Discontents: Courts and Abortion Policy in the United States and Spain*, *in* SECULARISM, WOMEN & THE STATE: THE MEDITERRANEAN WORLD IN THE 21ST CENTURY 195, 205 (Barry A. Kosmin & Ariela Keysar eds., 2009) (noting that public funding accompanied the liberalization of Spain's abortion laws).

19. Transnational law encompasses both international and foreign law. *See* Harold Hongju Koh, *International Law as Part of Our Law*, 98 AM. J. INT'L L. 43, 52–53 (2004).

provide an acceptable level of access to abortions in the United States, particularly in light of the recent adoption of a national health scheme. In this discussion, this Article comes back full circle to the basic framing of abortion, concluding that as health is increasingly seen as a human right in the United States, as it is elsewhere in the developed and developing world, abortion—particularly therapeutic abortion—may over time be viewed as just one of many components of reproductive health.[20] There can clearly be value in looking at abortion as a singular phenomenon. But it is no accident that the issue is currently framed in a more general, less confrontational way, within the larger context of health, by domestic reproductive rights advocates who are building toward the future.

I. GLOBAL MARKETS, DOMESTIC LAW, AND THE COMMODITY OF ABORTION

We begin by looking at abortion itself, ignoring for the time being its place in a larger continuum of health care. Indeed, in some respects, abortion is distinct from other aspects of reproductive health. For example, unlike some areas of reproduction—conception, for instance—safe abortion always requires the involvement of a medical professional.[21] For medical abortions—those brought about by taking drugs to end a pregnancy—the clinician's involvement will be significant but less direct, and will particularly focus on providing medical assessments both before and after termination of the pregnancy to ensure the safety of the procedure.[22] For surgical abortion—where the fetus is physically removed using special instruments—the medical professional will perform the surgery to terminate the pregnancy and provide follow-up care as necessary.[23]

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20. In the United States, health care is increasingly framed in human rights terms. *See, e.g.*, Senator Edward M. Kennedy, *Health Care as a Basic Human Right: Moving from Lip Service to Reality*, 22 HARV. HUM. RTS. J. 165, 165 (2009).

21. The World Health Organization ("WHO") defines an unsafe abortion as "a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both." SAFE MOTHERHOOD UNIT, WORLD HEALTH ORG., STUDYING UNSAFE ABORTION: A PRACTICAL GUIDE 3 n.1 (1996), *available at* http://whqlibdoc.who.int/hq/1996/WHO_RHT_MSM_96.25.pdf.

22. *See* Sonya B. Gamble et al., *Abortion Surveillance—United States, 2005*, MORBIDITY & MORTALITY WKLY. REP. (Ctrs. for Disease Control & Prevention, Atlanta, Ga.), Nov. 28, 2008, at 1, 6–8, *available at* http://cdc.gov/mmwr/PDF/ss/ss5713.pdf.

23. For one hospital's description of the preparation, procedure, and recovery for a first trimester surgical abortion, see University of California, San Francisco Medical Center, Abortion, Surgical First Trimester, Preparation, http://www.ucsfhealth.org/adult/

Further, unlike many areas of reproductive health such as birth, adoption, or use of reproductive technologies, the result of a successful abortion is the absence of production rather than production of a child. This latter point is particularly salient when examining issues of globalization, marketization, and commodification of reproduction. Because the outcome of abortion is the absence of production, and because both medical and surgical abortion involve a specialized type of personal service rather than simply a portable good, it remains a peculiarly local and personal phenomenon at a time when other aspects of reproduction that *produce*—such as reproductive technologies and international adoption—are increasingly tied directly to competitive global markets.[24]

Yet despite the essentially local nature of the abortion procedure itself, abortion policy also has global implications in the United States and elsewhere. It has an impact on world population: in 2003, there were approximately forty-two million abortions worldwide, somewhat down from forty-six million in 1996.[25] Abortion involves international commerce: the pharmaceutical product used as an abortifacient, Mifepristone, is manufactured in France and China and marketed worldwide by multinational drug companies Exelgyn Laboratories and Danco Laboratories.[26] Abortion spurs movement of people across borders: in some places, there is an active transnational market for a range of abortion services. For example, abortion is illegal in Ireland except when required to save the woman's life.[27] In all other cases, to obtain a safe medical or surgical abortion, Irish women must travel abroad, usually to England.[28] The significant time and expense

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medical_services/womens_health/gynecology/conditions/1surgabortion/signs.html (last visited Apr. 10, 2010).

24. *See, e.g.*, Radin, *supra* note 16, at 1933 ("At the moment, it does not seem that women's reproductive capabilities are as commodified as their sexuality. Of course, we cannot tell whether this means that reproductive capabilities are more resistant to commodification or whether the trend toward commodification is still at an early stage.").

25. GUTTMACHER INST., *supra* note 18, at 1.

26. Philip P. Pan, *Chinese to Make RU-486 for U.S.*, WASH. POST, Oct. 12, 2000, at A1; *see* The Electronic Medicines Compendium, Mifegyne, Summary of Product Characteristics, http://emc.medicines.org.uk/medicine/617/SPC/Mifegyne/ (last visited Apr. 10, 2010).

27. *E.g.*, Attorney General v. X, [1992] 1 I.R. 1, 3 (Ir.) (noting that abortion is permissible only when there is a statistical probability of a "real and substantial risk to the life of the mother" if the pregnancy is not terminated).

28. Ir. CONST., 1937, art. 40.3.3, *amended by* Ir. CONST. amend. XXIII, *available at* http://www.taoiseach.gov.ie/attached_files/html%20files/Constitution%20of%20Ireland%20%28Eng%29.htm (last visited Apr. 10, 2010).

that such travel entails exacerbates class differences in abortion availability, since low-income Irish women are much less likely to be able to afford the procedure on those terms.[29] Beyond this specific example, according to one survey, approximately twenty-six percent of the world's people live in places where abortion is highly restricted and where there may be "underground railroads" to jurisdictions where abortion is legal.[30]

On a more structural level, poverty itself, exacerbated by global markets, is an impediment to obtaining safe abortions.[31] Suffice it to say here that poverty has an effect on access to a full range of health care services, including abortion.[32] Low-income women in the United States and elsewhere are less likely to have the means to obtain contraception regularly, are therefore more likely to have unwanted pregnancies, are then more likely to want to end their unwanted pregnancies with abortions, yet are also less likely to be able to afford the unsubsidized cost of an abortion procedure, including any ancillary costs arising from travel to a provider.[33]

These financial impediments to obtaining an abortion are obvious since abortion is a service sold by medical professionals and pharmaceutical companies, and there is a price attached to the procedure. Sometimes the price tag for an abortion is quite hefty. In the United States, the median cost of a medical abortion at ten weeks of gestation is $430.[34] At twenty weeks, the median cost of a medical

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29. For a description of Irish women's experiences seeking abortions across borders, see generally Alyssa Best, *Abortion Rights Along the Irish-English Border and the Liminality of Women's Experiences*, 29 DIALETICAL ANTHROPOLOGY 423 (2005).

30. *See* CTR. FOR REPROD. RIGHTS, THE WORLD'S ABORTION LAWS 2007, http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Abortion%20Map_FA.pdf. For discussion of such an "underground railroad" in the United States, see generally Janessa L. Bernstein, Comment, *The Underground Railroad to Reproductive Freedom: Restrictive Abortion Laws and the Resulting Backlash*, 73 BROOK. L. REV. 1463 (2008).

31. *E.g.*, GIOVANNI ANDREA CORNIA & JULIUS COURT, UNITED NATIONS UNIV. WORLD INST. FOR DEV. ECON. RESEARCH, POLICY BRIEF NO. 4: INEQUALITY, GROWTH AND POVERTY IN THE ERA OF LIBERALIZATION AND GLOBALIZATION 17–19 (2001), *available at* http://www.wider.unu.edu/publications/policy-briefs/en_GB/pb4/; SUSHEELA SINGH ET AL., GUTTMACHER INST., ABORTION WORLDWIDE: A DECADE OF UNEVEN PROGRESS 23–24 (2009), *available at* http://www.guttmacher.org/pubs/AWWfullreport.pdf.

32. *See generally* Solomon R. Benatar, *Global Disparities in Health and Human Rights: A Critical Commentary*, 88 AM. J. PUB. HEALTH 295, 296 (1998) (noting the role of poverty in exacerbating threats to health).

33. SINGH ET AL., *supra* note 31, at 28.

34. Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 6, 14 (2008).

abortion is $1,260, with some surgical abortions at that stage costing upwards of $4,500.[35] Many women in the United States cannot afford such a costly procedure.[36] Only seventeen states provide state funding to pay for "medically necessary" abortions needed by low-income women; many of those states recognize that such funding is required as a matter of equality or substantive due process under their state constitutions.[37] In the majority of the United States, however, abortion access follows the federal Hyde Amendment's restrictions on public funding of the procedure through Medicaid. Thus, in most states, access to abortion is contingent on the woman's ability to pay, except in instances where a low-income pregnant woman's life is endangered by continuing the pregnancy or when the pregnancy is the result of rape or incest.[38]

Because of these federal and state restrictions on public funding, eighty-seven percent of abortions in the United States are privately funded, either paid for by individuals or through insurance.[39] In the United States, this private "market" for abortion services coexists uneasily with the notion, repeatedly reaffirmed by the U.S. Supreme Court, that abortion is a fundamental constitutional right, at least in the early stages of the pregnancy.[40] At first blush, this seems

35. *Id.*

36. National Poverty Center, University of Michigan, Poverty in the United States: Frequently Asked Questions, http://www.npc.umich.edu/poverty/ (last visited Apr. 10, 2010). According to the National Poverty Center, "Poverty rates are highest for families headed by single women, particularly if they are black or Hispanic. In 2008, 28.7 percent of households headed by single women were poor . . . ." *Id.*

37. Seventeen states provide such funding: Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia. NAT'L ABORTION FED'N, PUBLIC FUNDING FOR ABORTION: MEDICAID AND THE HYDE AMENDMENT 2 (2006), *available at* http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/public _funding.pdf. Six more—Indiana, Iowa, Mississippi, Utah, Virginia, and Wisconsin—provide more limited funding in cases of fetal abnormalities or health endangerment. *Id.*

38. *See, e.g.*, Hyde Amendment, Omnibus Appropriations Act of 2009, Pub. L. No. 111-8, §§ 613–614, 123 Stat. 524, 676–77 (2009). Medicaid enrollees may be eligible for assistance on this basis, but Medicaid maximum eligibility requirements range from as low as eighteen percent of the poverty line, with an average of sixty-five percent of the poverty line (or an annual income of $11,160 for a family of three). Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL'Y REV. 12, 12 (2007).

39. Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 16, 20 (2003).

40. In *Roe v. Wade*, the Supreme Court first found the right to abortion to be protected under the Fourteenth Amendment Due Process Clause, striking down Texas abortion criminalization laws. 410 U.S. 113, 153 (1973). However, the Court has upheld

contradictory. Under U.S. law, violation of an established constitutional right generally gives the affected party a claim against the government.[41] But if the government is under no obligation to pay for the procedure, what is left of the right has little practical significance for many women.

This is the fundamental impact of *Maher v. Roe*[42] and *Harris v. McRae*,[43] both of which held that the government can permissibly leave abortion access to be regulated by the marketplace despite abortion's status as a "fundamental right."[44] Under this approach, legal abortion is not a right in the sense of placing a special affirmative obligation on the government. Rather, the government's obligations are entirely passive, and abortion is left to compete with other public priorities for funding. If public abortion funding loses out in the legislature, the private market will control access to legal abortions for all but the small minority of women who qualify for public funding despite the Hyde Amendment restrictions. As the Court stated in *Maher*, nothing prevents a state government from making "a value judgment favoring childbirth over abortion, and . . . implement[ing] that judgment by the allocation of public funds."[45] South Dakota has exercised just such a prerogative by narrowing the provision of public funding to instances where a woman's life is endangered by the pregnancy, refusing the abortion funding for rape and incest victims made available under federal law.[46]

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both state and federal limitations on this right. In *Harris v. McRae*, the Supreme Court held that states receiving Medicaid are not required to fund abortions where federal reimbursement is barred due to the Hyde Amendments. 448 U.S. 297, 311 (1980). *Planned Parenthood of Southeastern Pennsylvania v. Casey*, in a plurality decision, upheld the constitutional right to abortion, but lowered the standard of review for state regulations restricting that right to the undue burden standard. 505 U.S. 833, 879–901 (1992). *Gonzales v. Carhart* upheld the federal Partial-Birth Abortion Ban Act of 2003, holding that the restriction did not impose an undue burden on due process rights. 550 U.S. 124, 146 (2007).

41. *See, e.g.*, Saenz v. Roe, 526 U.S. 489, 507 (1999) (finding that a welfare scheme intended to deter travel across state lines violated the constitutional right to travel); *see also* RONALD DWORKIN, TAKING RIGHTS SERIOUSLY 139 (1978) (defining a claim of right as "a special . . . sort of judgment about what is right or wrong for governments to do"). In this discussion, I use "claim" to denote a broader concept than "cause of action."

42. 432 U.S. 464 (1977).

43. 448 U.S. 297 (1980).

44. *Id.* at 317; *Maher*, 432 U.S. at 475.

45. *Maher*, 432 U.S. at 474.

46. "Any person who performs, procures or advises an abortion other than authorized by chapter 34-23A is guilty of a Class 6 felony." S.D. CODIFIED LAWS § 22-17-5 (2006). Section 34-23A provides the statutory framework for legal abortion. *See* S.D. CODIFIED LAWS §§ 34-23A-1 to 34-23A-5 (2006). From the first week of pregnancy through the

Insofar as the government is not required to ensure access to abortion, abortion is again different from some other rights protected under the U.S. Constitution that have been construed to require affirmative government action and expenditures. For example, the right to counsel in criminal proceedings provided under the Sixth Amendment is effectuated through provision of government-paid lawyers for those who cannot afford their own counsel.[47] Similarly, protection of due process rights may mandate affirmative government actions to provide fair hearings and other procedural protections that come with a price tag.[48]

In many other areas, of course, the government has not shouldered such a concrete affirmative obligation to protect the exercise of constitutional rights.[49] Nevertheless, the nature of abortion arguably distinguishes it from those areas where there may be a possibility of achieving some of the benefit of the right even without the government's affirmative support. For example, compare the law relating to the First Amendment. There are some parallels with abortion to be sure: speech is a constitutional right, but like abortion, the government does not have a general duty to provide financial support to the speech.[50] In fact, the Supreme Court in *Rust v.*

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twenty-fourth, the decision lies within the doctor's medical judgment; after the twenty-fourth week, abortion is legal only when necessary to preserve the life or health of the mother. *See* Guttmacher Inst., State Facts About Abortion: South Dakota, http://www.guttmacher.org/pubs/sfaa/pdf/south_dakota.pdf (last visited Apr. 10, 2010). South Dakota's program appears to put it in violation of the requirements for continued Medicaid participation.

47. Gideon v. Wainwright, 372 U.S. 335, 339–40 (1963). For additional background and a critique of current implementation mechanisms, see generally THE BRENNAN CTR. FOR JUSTICE, ELIGIBLE FOR JUSTICE: GUIDELINES FOR APPOINTING DEFENSE COUNSEL (2008).

48. *See, e.g.*, Goldberg v. Kelly, 397 U.S. 254, 266 (1970) (mandating fair hearings before termination of welfare benefits). Other contexts in which upholding constitutional rights comes with an administrative price tag could include the warrant requirement, the right to vote, eminent domain compensation, and the right to a jury trial.

49. For example, the right to "keep and bear arms" protected by the Second Amendment to the U.S. Constitution does not give rise to a government obligation to affirmatively provide such arms to people. For a discussion of the Second Amendment's meaning, see District of Columbia v. Heller, 128 S. Ct. 2783, 2831 (2008).

50. *See* Legal Servs. Corp. v. Velazquez, 531 U.S. 533, 549 (2001) (finding that attaching prohibitions to federal funding that prevented recipients from engaging in representation to reform welfare law was in violation of free speech rights under the U.S. Constitution); Rust v. Sullivan, 500 U.S. 173, 179–80, 196 (1991) (finding that the Title X prohibitions on engaging in abortion counseling, referral, and activities advocating abortion did not violate petitioners' free speech rights); *see also* Frederick Schauer, *Towards an Institutional First Amendment*, 89 MINN. L. REV. 1256, 1260–61 (2005) (noting

Sullivan[51] underscored that, while clinics and doctors may have a First Amendment right to offer information on access to abortion, the government is under no obligation to fund such speech and can even wield its Spending Clause power to deny public funding to those who use non-governmental funds to engage in the disfavored speech.[52]

Unlike the abortion procedure, however, speech has many gradations. A speaker may have the opportunity and resources to deliver ideas in a more limited forum or in a more circumscribed format. Similarly, the message may be delayed but still delivered. In this age of the Internet, a speaker may be able to find a low- or no-cost way of delivering content that still has potential to reach a broad audience.[53] In sum, even without government support, low-income people may not be entirely excluded from the communication marketplace and will often be able to find ways to deliver and receive a range of messages, even if not as perfectly or efficiently or broadly as they might have had they received public funding.[54]

In contrast, the abortion procedure is an all-or-nothing proposition that comes with a strict time line attached. An abortion cannot be performed in stages as the funding becomes available, and it must be performed within a fairly tight time frame, when it is safe and legal.[55] Once the time frame has passed, the opportunity for a legal abortion may be entirely over and after-the-fact measures can provide no individual remedy.[56] Given these factual realities that

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that at its root, the right to free speech "is about the (negative) liberty" of people to behave in certain ways (footnote omitted)).

51. 500 U.S. 173 (1991).

52. *See id.* at 196, 199.

53. While the digital divide persists, there is evidence that it is narrowing. *See* Catherine Holahan, *America's Digital Divide Narrows*, BUS. WK., Mar. 15, 2007, http://www.businessweek.com/technology/content/mar2007/tc20070315_573361.htm?chan=top+news_top+news+index_technology.

54. Social media exemplifies these possibilities. *See* KEITH HAMPTON ET AL., SOCIAL ISOLATION AND NEW TECHNOLOGY 3 (2009) (finding that social media activities are associated with exposure to a wider range of diverse opinions and backgrounds).

55. For example, the Houston Women's Clinic posts its rates for abortion procedures at each stage of the pregnancy. According to the chart, rates increase at 11.5 weeks and 14.5 weeks, and the clinic does not perform abortions after 15.5 weeks. *See* Houston Women's Clinic, Fees & Instructions, http://www.houstonwomensclinic.com/fees.html (last visited Apr. 19, 2010).

56. For example, Alicja Tysiac ultimately received some financial compensation for the distress caused when she was prevented from terminating her pregnancy, but her life has nevertheless changed dramatically and irrevocably through the birth of her child and her loss of sight, aggravated by the childbirth. *See* Tysiac v. Poland, 45 Eur. Ct. H.R. 42, ¶ 163 (2007), *available at* http://www.unhcr.org/refworld/category,LEGAL,,,POL,470376112,0.html; Press Release, Interights, European Court Confirms Judgment in

distinguish abortion from some other constitutionally protected rights, the absence of government funding is a particularly salient issue in terms of the right's protection and exercise.

These issues have been addressed in a number of state jurisdictions that have taken access to legal abortion out of the exclusive control of the private marketplace by extending public funding.[57] In those states, courts have generally adopted an equality framework, ruling that their state constitutions mandate financial neutrality as between abortion and other health care procedures, or as between procedures specific to men or unique to women.[58] That is, when health care funds are provided more generally for medically necessary procedures, funding for abortion cannot be singled out for special exclusion.[59] In some states, courts have also looked to the state

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Polish Access to Termination of Pregnancy Case (Sept. 25, 2007), *available at* http://www.interights.org/view-document/index.htm?id=207 (describing the aftermath of Tysiac's pregnancy).

57. *See supra* note 37 and accompanying text.

58. *See* Scott A. Moss & Douglas M. Raines, *The Intriguing Federalist Future of Reproductive Rights*, 88 B.U. L. REV. 175, 206 (2008).

59. Seventeen states require public funding of medically necessary abortions, most based on state constitutional rights. *See* NAT'L ABORTION FED'N, *supra* note 37, at 2; *e.g.*, Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963, 972 (Alaska 1997) (ruling that a hospital policy prohibiting certain elective abortions was in violation of state constitutional privacy rights); Simat Corp. v. Ariz. Health Care Cost Containment Sys., 56 P.3d 28, 33 (Ariz. 2002) (holding that the state could not refuse to fund medically necessary abortions for indigent women based on the state constitution privilege and immunities clause); Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779, 798 (Cal. 1981) (holding that the California Budget Acts of 1978, 1979, and 1980 excluded funds for payment of elective abortions and were found to violate the rights of privacy within the state constitution. The court further stated "There is no greater power than the power of the purse. If the government can use it to nullify constitutional rights, by conditioning benefits only upon the sacrifice of such rights, the Bill of Rights could eventually become a yellowing scrap of paper."); Doe v. Maher, 515 A.2d 134, 162 (Conn. Super. Ct. 1986) (concluding that a regulation restricting Medicaid payment for therapeutic abortions to those necessary to save the life of the mother violated Connecticut's due process and equal rights amendments); Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387, 404 (Mass. 1981) (finding that statutes singling out abortion funding for exclusion from Medicaid funding were in violation of the state's constitutional right to privacy); N.M. Right to Choose/NARAL v. Johnson, 1999-NMSC-005, ¶ 52, 126 N.M. 788, 804, 975 P.2d 841, 857 (finding the court could order the state to pay expenses for women who were Medicaid-eligible and in need of medical abortions); Women's Health Ctr. of W. Va. v. Panepinto, 446 S.E.2d 658, 667 (W. Va. 1993) (ruling that a state statute banning the use of state Medicaid funds for abortions except in limited circumstances was in violation of West Virginia's state constitution due process clause); *see also* Center for Reproductive Rights, Portrait of Injustice: Abortion Coverage Under the Medicare Program (May 1, 2004), http://reproductiverights.org/en/document/portrait-of-injustice-abortion-coverage-under-the-medicaid-program (listing the states that do and do not provide public funding for abortion).

constitution's due process protections, finding support for abortion funding as a matter of substantive due process necessary to protect the practical availability of a fundamental right.[60] In Indiana, the state's privileges and immunities clause formed the basis for a ruling that the state must pay for a wider category of abortions for low-income women.[61]

In *Doe v. Maher*,[62] the Connecticut Superior Court went so far as to assert that the U.S. Supreme Court's decisions in the area—*Roe v. Wade*, *Harris v. McRae*, and *Maher v. Roe*—could not be reconciled.[63] According to the Connecticut court, "Medicaid reimbursement funds are made available for all the health care costs of women, including these medical costs necessary to carry the fetus to term, but not for the medically necessary abortion. Surely, this constitutes infringement on the right to an abortion."[64] Similarly, in *Right to Choose v. Byrne*,[65] the Supreme Court of New Jersey opined that

> the funding restriction gives priority to potential life at the expense of maternal health.
>
> . . . Given the high priority accorded in this State to the rights of privacy and health, it is not neutral to fund services medically necessary for childbirth while refusing to fund medically necessary abortions. Nor is it neutral to provide one woman with the means to protect her life at the expense of a fetus and to force another woman to sacrifice her health to protect a potential life.[66]

Interestingly, though the discussions in these cases focus on inequality or due process/privacy, the language used evokes the market and, indeed, does not challenge the basic notion of abortion as a service for sale. Judicial opinions repeatedly mention the dilemma that the market places on low-income women who seek abortions.[67] However, the judges' concerns are not about the

60. *E.g.*, *Moe*, 417 N.E.2d at 396–97.

61. Humphreys v. Clinic for Women, Inc., 796 N.E.2d 247, 249 (Ind. 2003).

62. 515 A.2d 134 (Conn. Super. Ct. 1986).

63. *Id.* at 151.

64. *Id.* at 151–52; *see also* Women of the State v. Gomez, 542 N.W.2d 17, 29 (Minn. 1995) ("[W]e find the U.S. Supreme Court's decision in *McRae* unpersuasive.").

65. 450 A.2d 925 (N.J. 1982).

66. *Id.* at 935.

67. *See, e.g.*, *Women of the State*, 542 N.W.2d at 31; N.M. Right to Choose/NARAL v. Johnson, 1999-NMSC-005, ¶ 50, 126 N.M. 788, 803, 975 P.2d 841, 856 ("Pregnant women who qualify for medical assistance from the Department are, by definition, unable to pay for their own medical expenses. Such women have only a limited period of time to obtain

commodification of the abortion transaction but the lack of government neutrality—that is, the undue interference of the government in the market.[68] Whereas *Harris* and *Maher* viewed denial of public funding as a neutral act, state courts upholding such funding view it as necessary to maintain neutrality in the context of the range of government funding made available for other procedures. As the court stated in striking down the statute in *Right to Choose*, "for a woman who cannot afford either medical procedure, the statute skews the decision in favor of childbirth at the expense of the mother's health."[69] According to the Supreme Court of New Jersey, "We simply cannot say that an indigent woman's decision whether to terminate her pregnancy is not significantly impacted by the state's offer of comprehensive medical services if the woman carries the pregnancy to term."[70]

In contrast to the market-based approach that dominates abortion availability in the United States, abortion has attained the status of a universal human right internationally. In general, international norms aver that abortion's status as a right requires that governments take steps to enable women to exercise that right.[71] These norms essentially move abortion from the realm of commodification, where the market is the determinative factor in accessing the services and government neutrality is required (however defined), to a more purely rights regime that places affirmative obligations on the government regardless of cost and regardless of market impacts. As discussed more fully below, the market-based

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a safe, relatively inexpensive abortion after discovering that they are pregnant. The expense of obtaining an abortion increases two to six times in the second trimester. Further, it is not unreasonable to infer that the conditions which make an abortion medically necessary also may have a disabling effect on a pregnant woman's earning capacity.").

68. *See, e.g.*, Women's Health Ctr. of W. Va. v. Panepinto, 446 S.E.2d 658, 667 (W. Va. 1993) (stating that the state's provision of medical care for the poor must be implemented in a neutral manner).

69. *Right to Choose*, 450 A.2d at 934–35.

70. *Women of the State*, 542 N.W.2d at 31.

71. *See, e.g.*, Fourth World Conference on Women, Beijing, P.R.C., Sept. 4–15, 1995, *Report*, ¶¶ 17, 30, 97, U.N. Doc. A/CONF.177/20/Rev.1 (Jan. 1, 1996); International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, *Report*, ¶¶ 7.3, 7.6, U.N. Doc. A/CONF.171/13/Rev.1 (Oct. 18, 1994), *available at* http://www.unfpa.org/publications/detail.cfm?ID=275 ("The promotion of the responsible exercise of these [reproductive] rights for all people should be the fundamental basis for government—and community-supported policies and programmes in the area of reproductive health, including family planning."); World Conference on Human Rights, June 14–25, 1993, *Vienna Declaration and Programme of Action*, ¶ 19, U.N. Doc. A/CONF.157/23 (July 12, 1993).

approach to abortion has been rejected recently by a number of international bodies and national legislatures. These recent developments highlight the ongoing tension between fundamental rights and commodification while also suggesting a potential for globalization of rights as well as globalization of markets.

II. ACCESS TO ABORTION AS A COMPONENT OF HUMAN RIGHTS: RECENT INTERNATIONAL AND COMPARATIVE LAW

A. The International Human Rights Law Context

Abortion has long been a contested issue in international law as well as domestic law. Few international human rights treaties address abortion explicitly. Recently, for example, as the prospects for U.S. ratification of the women's rights treaty grow, much controversy has swirled around the extent to which the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW") addresses abortion.[72] The text of CEDAW does not explicitly speak to the issue. In the context of women's health, CEDAW simply provides that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[73]

However, the CEDAW Committee has interpreted this language to require state parties to "respect, protect and fulfill women's rights to health care"[74] and has used its monitoring authority to criticize nations that do not provide adequate access to abortion.[75] CEDAW's potential impact on the legal treatment of abortion in the United

72. *See* GLOBAL JUSTICE CTR., FALSE CHOICES: SACRIFICING EQUALITY TO GET CEDAW 1–2 (Nov. 9, 2007), http://www.globaljusticecenter.net/publications/CEDAW%20-%20ratification.pdf; Twisted Treaty Shafts Women (Feb. 4, 2009, 08:00 EST), http://www.rhrealitycheck.org/blog/2009/02/03/twisted-treaty-shafts-women.

73. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, Art. 12, ¶ 1, U.N. Doc. A/34/46 (Dec. 18, 1979), *available at* http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm.

74. Comm. on the Elimination of Discrimination Against Women, General Recommendation 24: Women and Health, ¶ 13, U.N. Doc. HRI/GEN/1/Rev.5 (2001).

75. *See, e.g.*, Convention on the Elimination of All Forms of Discrimination Against Women, Santiago, Chile, Aug. 7–25, 2006, *Concluding Comments*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (Aug. 26, 2006) ("The Committee . . . remains concerned that abortion under all circumstances is a punishable offense under Chilean law, which may lead women to seek unsafe, illegal abortions, with consequent risks to their life and health, and that clandestine abortions are a major cause of maternal mortality.").

States has become a signal point of contention as Senators and members of the public debate the treaty's possible ratification.[76]

Though the international human rights treaties are generally silent on abortion, other U.N. Documents have been more explicit. For example, the Beijing Platform for Action states in paragraph 97:

> Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problems and injuries are preventable through improved access to adequate health-care services, including safe and effective family planning methods and emergency obstetric care, recognizing the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[77]

Regional treaties such as the Women's Protocol to the African Charter on Human and Peoples' Rights, may go even further to explicitly address government obligations to fund women's access to therapeutic abortion. Under the African Women's Protocol, "States Parties shall take all appropriate measures to . . . protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[78]

A common, and deep, thread through these international documents is the connection between abortion rights (including

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76. *See, e.g.*, Am. Bar Ass'n Section of Individual Rights & Responsibilities, Convention on the Elimination of All Forms of Discrimination Against Women, Fear vs. Fact, *available at* http://www.abanet.org/irr/fear_fact.html (last visited Apr. 19, 2010) (listing as a "fear" that CEDAW addresses abortion and as a "fact" that CEDAW is "abortion neutral").

77. *See* Fourth World Conference on Women, *supra* note 71, ¶ 97.

78. *See* Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Sept. 13, 2000, O.A.S. CAB/LEG/66.6, art. 14(2)(c) (outlining women's health and reproductive rights that compel States Parties to provide (1) access to adequate and affordable healthcare and educational services; (2) health and nutritional services throughout pregnancy; and (3) protection of reproductive rights by allowing abortions in circumstances such as rape, incest, and when there are health concerns for the mother or fetus).

access to the procedure) and human dignity, the fundamental currency of human rights set out in Article 1 of the Universal Declaration of Human Rights ("UDHR").[79] As stated in the Universal Declaration and reiterated in CEDAW, "all human beings are born free and equal in dignity and rights and . . . everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex."[80] Perhaps reflecting the reality of the law's migration, the concept of "human dignity" is by no means foreign to U.S. law—it has also served as a touchstone in U.S. jurisprudence, notably making an appearance in *Lawrence v. Texas*.[81]

B. Recent Foreign and International Decisions Expanding Abortion Rights

In addition to the language of treaties and formal conference platforms, the fundamental nature of abortion has been recognized in a series of recent cases from international bodies and national courts outside of the United States. As Mindy Roseman of Harvard Law School recently wrote, these decisions "may in time be considered something of a trend."[82] In the meantime, they serve at least as a counterweight to the regulation of abortion access primarily by market forces and they suggest the possibility that the "globalization" of human rights, and particularly a human right to health, might supersede the market-based approach to the issue that currently prevails in the United States. While none of these cases directly addressed the issue of public funding of abortion, as described below, in each instance, in the context of a well-established national health

79. Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under* Casey/Carhart, 117 YALE L.J. 1694, 1736 n.119 (2008).

80. Convention on the Elimination of All Forms of Discrimination Against Women pmbl., Sept. 3, 1981, 27 U.S.T. 1909, 1909, 1249 U.N.T.S. 14, 14.

81. 539 U.S. 558, 567 (2003). *See generally* Maxine D. Goodman, *Human Dignity in Supreme Court Constitutional Jurisprudence*, 84 NEB. L. REV. 740 (2006) (explaining the role that human dignity played in *Lawrence v. Texas*); Vicki Jackson, *Constitutional Dialogue and Human Dignity: States and Transnational Constitutional Discourse*, 65 MONT. L. REV. 15 (2004) (discussing the prevalence of the role of human dignity in transnational documents); Siegel, *supra* note 79 (using a dignity-based approach to analyze the *Casey* and *Carhart* cases). For a discussion of the permeability of borders and transmission of legal ideas, see generally Judith Resnik, *Law's Migration: American Exceptionalism, Silent Dialogues and Federalism's Multiple Points of Entry*, 115 YALE L.J. 1564 (2006).

82. Mindy Jane Roseman, *Bearing Human Rights: Maternal Health and the Promise of ICPD*, *in* REPRODUCTIVE HEALTH AND HUMAN RIGHTS: THE WAY FORWARD 91, 108 (Laura Reichenbach & Mindy Jane Roseman eds., 2009).

system, public funding for legal abortion procedures followed the recognition of abortion rights.

The United Nations' Human Rights Committee's approach is demonstrated by the 2005 decision in *In re K.L.*,[83] an appeal by a Peruvian citizen to the United Nations. Under Peruvian law, abortion is generally criminal, but it is permitted—and paid for by the government—in cases where the physical and mental health of the mother is at risk of permanent damage.[84] Unfortunately, this "law on the books" is undermined by serious violations of abortion rights, as chronicled in a recent report by Human Rights Watch ("HRW").[85] According to HRW,

> Major obstacles to accessing therapeutic abortion in Peru include: vague and restrictive laws and policies on therapeutic abortion, the absence of a national protocol on eligibility and administrative procedures, ad hoc approval and referral procedures for legal abortions, and lack of accountability for non-service. These problems are compounded by healthcare providers' fear of prosecution or malpractice lawsuits, and low levels of awareness among women and healthcare providers about exceptions to the criminalization of abortion.[86]

K.L., a native of Peru, experienced these problems directly. She filed a petition in 2001 with the U.N. Human Rights Committee claiming that when she was a seventeen year-old, carrying an anencephalic fetus, and facing severe risks to her life and health if the pregnancy proceeded, she was denied an abortion by medical officials working for the Peruvian Ministry of Health.[87] K.L.'s complaint to the U.N. Committee set out several claims based on sex discrimination as well as discrimination in the exercise of her rights.[88]

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83. K.L. v. Peru, U.N. Human Rights Comm., U.N. Doc. CCPR/C/85/D/1153/2003 (Oct. 24, 2005).

84. CTR. FOR REPROD. LAW & POLICY, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES—LATIN AMERICA AND THE CARIBBEAN 171 (1997), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/wowlac_peru_0.pdf.

85. *See generally* HUMAN RIGHTS WATCH, MY RIGHTS, AND MY RIGHT TO KNOW: LACK OF ACCESS TO THERAPEUTIC ABORTION IN PERU (July 2008), *available at* http://www.hrw.org/sites/default/files/reports/peru0708_1.pdf (detailing the major obstacles to accessing therapeutic abortion in Peru).

86. HUMAN RIGHTS WATCH, COUNTRY SUMMARY: PERU (Jan. 2009), *available at* http://www.hrw.org/en/world-report/2009/peru.

87. K.L. v. Peru, U.N. Human Rights Comm., U.N. Doc. CCPR/C/85/D/1153/2003, ¶¶ 2.1–2.7 (Oct. 24, 2005).

88. *Id.* ¶¶ 3.1–3.9.

In the claim coming closest to an articulation of an affirmative substantive right to abortion, K.L. argued that the Peruvian Health Ministry had violated Article 24 of the International Covenant on Civil and Political Rights, requiring special care of minors, because "[n]either her welfare nor her state of health were objectives pursued by the authorities which refused to carry out an abortion on her."[89] Importantly, the U.N. Human Rights Committee's General Comment 17 on Article 24 of the International Covenant on Civil and Political Rights states that member nations should take "every possible economic and social measure . . . to reduce infant mortality and to . . . prevent [minors] from being subjected to acts of violence and cruel and inhuman treatment . . . ."[90] Considering this claim, the Committee noted the "special vulnerability of [K.L.] as a minor girl."[91] Placing an affirmative burden on the government to assist K.L., and giving weight to her claim that she did not receive "the medical and psychological support necessary in the specific circumstances of her case," the U.N. Committee found in 2005 that Peru had violated international human rights law by denying K.L. an abortion.[92]

The European Court of Human Rights' view is illustrated by a Polish citizen's appeal in the 2007 case of *Tysiac v. Poland*.[93] In the European Union, only Ireland and Malta have more restrictive abortion laws than Poland.[94] Under Polish law, abortions are allowed when the health of the mother or the fetus is threatened.[95] However, medical professionals have been very reluctant to openly perform the procedure because of fears of retribution.[96] According to one estimate, between 80,000 and 200,000 illegal abortions occur each

89. *Id.* ¶ 3.7.

90. U.N. Human Rights Comm., *General Comments Adopted by the Human Rights Committee, General Comment 17, Article 24 (35th Sess., 1989)*, *in* COMPILATION OF GENERAL COMMENTS AND GENERAL RECOMMENDATIONS ADOPTED BY THE HUMAN RIGHTS TREATY BODIES 1, ¶ 3, U.N. Doc. No. HRI/GEN/1/Rev.3 (Aug. 15, 1997).

91. K.L. v. Peru, U.N. Human Rights Comm., U.N. Doc. CCPR/C/85/D/1153/2003, ¶ 6.5 (Oct. 24, 2005).

92. *Id.*

93. 45 Eur. Ct. H.R. 42 (2007), *available at* http://www.unhcr.org/refworld/category,LEGAL,,,POL,470376112,0.html.

94. CTR. FOR REPROD. RIGHTS, THE WORLD'S ABORTION LAWS 2 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/pub_fac_abortionlaws2008.pdf.

95. Françoise Girard & Wanda Nowicka, *Clear and Compelling Evidence: The Polish Tribunal on Abortion Rights*, REPROD. HEALTH MATTERS, May 2002, at 22, 23.

96. Wanda Nowicka, *Contemporary Women's Hell: Polish Women's Stories*, REPROD. HEALTH MATTERS, Nov. 2005, at 160, 160.

year in Poland, with such black market abortions costing up to a year's salary.[97]

In 2000, doctors advised Alicja Tysiac that because of a preexisting condition of severe myopia, she could experience complete blindness if she carried her pregnancy to term.[98] She was a single mother in her thirties, carrying her third pregnancy, and she decided to have an abortion to preserve her eyesight.[99] Under Polish law, the abortion she sought was legal because of the risks to her health, yet she was unable to gain access to the procedure because no doctor would perform it.[100] She ultimately gave birth, but as a result of her deteriorating eyesight she cannot work or adequately care for her children, and she now requires daily assistance.[101]

Ms. Tysiac sued Poland before the European Court of Human Rights. In 2007, the Court held that the Polish government was in violation of Article 8 of the European Convention on Human Rights.[102] Article 8 states that "[e]veryone has the right to respect for his private and family life" and unlike U.S. privacy law, it places a positive obligation on the state to protect that right.[103] Here, the limited right to an abortion under Polish law was wholly undermined by the practical unavailability of the procedure. In issuing its ruling, the Court noted that the Convention on Human Rights "is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective."[104] In other words, a government does not comply with its obligations under international law by simply offering "paper" rights in statute books. It must develop a system where a right to abortion guaranteed under domestic law is in fact available in reality.[105]

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97. Girard & Nowicka, *supra* note 95, at 25.

98. *Tysiac*, 45 Eur. Ct. H.R. 42, ¶ 9.

99. Adam Easton, *Polish Woman Wins Abortion Case*, BBC NEWS (Warsaw, Pol.), Mar. 20, 2007, http://news.bbc.co.uk/2/hi/europe/6470403.stm.

100. *Polish Woman Denied Abortion Takes Case to European Court*, FEMINIST WIRE DAILY NEWSBRIEFS, Feb. 13, 2006, http://www.msmagazine.com/news/uswirestory.asp?id=9517.

101. Meghan Sapp, *Polish Woman Denied Abortion Awaits EU Judgment*, WOMEN'S E-NEWS, July 10, 2006, http://www.womensenews.org/story/abortion/060710/polish-woman-denied-abortion-awaits-eu-judgment; Interights.org, Tysiac v. Poland, http://www.interights.org/tysiac (last visited Apr. 19, 2010).

102. *Tysiac*, 45 Eur. Ct. H.R. 42, ¶ 130.

103. Convention for the Protection of Human Rights and Fundamental Freedoms art. 8, Apr. 11, 1950, Europ. T.S. No. 5.

104. *Tysiac*, 45 Eur. Ct. H.R. 42, ¶ 113.

105. This is increasingly an issue in the United States, where a majority of counties do not have any abortion provider, despite the constitutional guarantee of the right to choose.

The Mexican Supreme Court also recently liberalized Mexico's abortion jurisprudence. Latin America in general, and Mexico in particular, has historically been hostile to abortion rights.[106] In 2007, however, Mexico City liberalized its abortion law to decriminalize first trimester abortions.[107] Studies had shown that two to three thousand Mexican women were dying each year from the complications of illegal abortions.[108]

The Attorney General quickly challenged the Mexico City law as a violation of the Mexican Constitution; the Attorney General argued that a city did not have the authority to make a health law and that the power to issue such a law was reserved for the federal government.[109] But on August 28, 2008, the Mexican Supreme Court upheld the Mexico City law.[110] In a constitutional ruling, the Court determined that the Mexico City Assembly had the power to legislate on the issue of abortion.[111] Rejecting the argument put forward by one of the Supreme Court ministers (as the justices are called) that life begins at conception, the Court instead specifically recognized women's autonomy over reproductive decisions.[112] As stated by Justice Sergio Valls, " 'To affirm that there is an absolute constitutional protection of life in gestation would lead to the violation of the fundamental rights of women.' "[113]

Jones et al., *supra* note 34, at 11–13. In Colombia, the Constitutional Court recently grappled with one aspect of this issue—the question of providers' moral objection to abortion—by providing specific guidelines to limit such conscientious objection. *See infra* notes 122–24 and accompanying text.

106. Acknowledging Sexual and Reproductive Rights in Latin American Constitutions, http://www.rhrealitycheck.org/blog/2008/06/05/ackowledging-sexual-and-reproductive-rights-latin-american-constitutions (June 10, 2009, 07:00 EST).

107. James C. McKinley, Jr., *Mexico City Legalizes Abortion Early in Term*, N.Y. TIMES, Apr. 25, 2007, at A8, *available at* http://www.nytimes.com/2007/04/25/world/americas/25mexico.html.

108. Hector Tobar, *Lawmakers Vote to Legalize Abortion in Mexico City*, L.A. TIMES, Apr. 25, 2007, at A1, *available at* http://articles.latimes.com/2007/apr/25/world/fg-mexabort25.

109. *Mexico's High Court Upholds Abortion Law*, CNN, Aug. 28, 2008, http://www.cnn.com/2008/WORLD/americas/08/28/mexico.abortion/index.html.

110. Ken Ellingwood, *Mexico Court Backs Abortion Rights*, L.A. TIMES, Aug. 29, 2008, at A3, *available at* http://articles.latimes.com/2008/aug/29/world/fg-mexabortion29.

111. Olga R. Rodriguez, *Mexican Supreme Court Upholds Legal Abortion*, S.F. CHRON., Aug. 28, 2008, at A12, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/n/a/2008/08/27/international/i111158D69.DTL&feed=rss.news.

112. This account is based on the published reports of the decision in English prepared by the press and analysts at nongovernmental organizations cited here. No official English translation of the decision is available.

113. Sara M. Llana, *Mexico's Supreme Court Upholds Abortion Law*, CHRISTIAN SCI. MONITOR, Aug. 29, 2008, at 25 (quoting Justice Sergio Valls). Though the Mexican

Similarly, in 2006, the Constitutional Court of Colombia ended that nation's abortion ban[114] and went further in 2009 to articulate specific government implementation obligations.[115] The initial petition to the Court, filed by attorney Monica Róa, challenged the constitutionality of Colombia's abortion law, which categorically prohibited abortion.[116] Róa argued that the Constitution of Colombia requires exceptions to the prohibition of abortion that protect a woman's fundamental rights to life, health, privacy, and dignity.[117] In a landmark decision, the Constitutional Court ruled that abortion must be permitted when a pregnancy threatens a woman's life or health, in cases of rape or incest, and in cases where the fetus has malformations incompatible with life outside the womb.[118] Explicitly incorporating international human rights standards, the court declared that the abortion ban violated women's fundamental human rights.[119] Further, the court stressed the government's affirmative obligations to "eliminate barriers impeding women's effective

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Supreme Court decision stands, there has been a significant popular backlash following the Mexico City changes, with many Mexican states adopting more restrictive abortion policies. *See, e.g.*, Diego Cevallos, *Mexico: Avalanche of Anti-Abortion Laws*, INTER PRESS SERVICE, May 22, 2009, http://ipsnews.net/news.asp?idnews=46946 (discussing constitutional amendments passed by several Mexican states since the Mexico Supreme Court decision and how these "anti-abortion laws" afford women less protection).

114. Sentencia C-355/06 [2006], Corte Constitucional [Constitutional Court], (Colom.), *available at* http://www.unifr.ch/ddp1/derechopenal/jurisprudencia/j_20080616_03.pdf (in Spanish).

115. Emilia Ordolis, *Lessons from Colombia: Abortion, Equality and Constitutional Choices*, 20 CANADIAN J. WOMEN & L. 263, 264 (2008). *See generally* Camilo Eduardo Martinez Orozco, Ruling Allowing Induced Abortion in Colombia: A Case Study (May 2007) (unpublished M.A. thesis, Linkoping Univ., Sweden), *available at* http://liu.diva-portal.org/smash/record.jsf?pid=diva2:23733 (providing a detailed discussion concerning the ethical implications of the Court's decision).

116. For more information on attorney Monica Róa and her role in the case, see *"It's Possible to Change the World," Colombian Lawyer Monica Roa Speaks to Students, Activists*, IPAS, Apr. 5, 2007, http://www.ipas.org/Library/News/News_Items/Its_possible_to_change_the_world_Colombian_lawyer_Monica_Roa_speaks_to_students_activists.aspx; *see also* Nicole Karsin, *Colombians Push Abortion onto National Agenda*, WOMEN'S E-NEWS, Dec. 22, 2005, http://www.womensenews.org/story/health/051222/colombians-push-abortion-national-agenda (discussing Monica Róa's historical efforts to push abortion issues onto Colombia's national agenda).

117. Ass'n for Women's Rights in Dev., *Challenging Abortion Law in Colombia: An Interview with Monica Roa*, WHRNET, July 2005, http://www.womenslinkworldwide.org/pdf_programs/prog_rr_col_articles_25.pdf.

118. Juan Forero, *Colombian Court Legalizes Some Abortions*, N.Y. TIMES, May 12, 2006, at A14, *available at* http://www.nytimes.com/2006/05/12/world/americas/12colombia.html?_r=1.

119. Ordolis, *supra* note 115, at 265.

enjoyment of their internationally recognized rights."[120] Recognizing substantive rights violations as well as issues of inequality raised by the abortion ban, the court declared that it is the "duty of all states to offer a wide range of high quality and accessible health services, which must include sexual and reproductive health services."[121]

Three years later in 2009, the Colombian Constitutional Court refined its guidance on abortion.[122] In that case, a woman sought a legal therapeutic abortion needed because of a severely malformed fetus. Though the procedure was legal, the health care provider sought a judicial order before providing the abortion. The judge, however, refused to grant the order, citing his own personal beliefs about abortion. In its decision, the Constitutional Court clarified that conscientious objection is not available to excuse judges from considering abortion cases. Further, the Court spelled out specific practices that must be followed in order to make legal abortion truly accessible throughout the country.[123] Among other things, the Colombian Ministry of Education and Social Protection must produce and implement a plan to promote the sexual and reproductive rights of women, including distribution of information about the grounds for legal abortion.[124]

In sum, these four recent decisions, all from countries where abortion has historically been highly contested, all recognize positive responsibilities of governments to provide at least some limited access to abortion as a matter of fundamental rights. The narrowest of the cases, from Mexico City, simply upholds the legislature's decision to liberalize abortion laws. The Colombian decision, in contrast, articulates positive obligations for the legislature and carves out the standards that should be implemented as a matter of positive law.

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120. *Id.* at 268 (internal quotations omitted).

121. Sentencia C-355/06 [2006], Corte Constitucional [Constitutional Court] (Colom.), *available at* http://www.unifr.ch/ddp1/derechopenal/jurisprudencia/j_20080616_03.pdf (in Spanish).

122. Sentencia T-388/09 [2009], Corte Constitucional [Constitutional Court] (Colom.), *available at* http://www.corteconstitucional.gov.co/relatoria/2009/T-388-09.htm (in Spanish).

123. Press Release, Women's Link Worldwide, Colombian Constitutional Court Continues to Set Precedent Case Law on Abortion (Oct. 20, 2009), http://www.womenslinkworldwide.org/pdf_press/press_release_20091020_en.pdf.

124. *Id.*

C. Public Funding to Support Abortion Access for Low-Income Women

In each of these countries, despite the controversy surrounding the abortion procedure, funding for abortion has followed the legalization of therapeutic abortion procedures as a matter of course. While implementation leaves much to be desired in some cases, the law at least provides for such public funding.

In Peru, the procedure to which K.L. was entitled—an abortion to preserve her health—should, as a matter of law, have been funded through the Peruvian national health system.[125] Likewise, Poland has a comprehensive national health plan which, on paper, provides public funding to low-income women in Alicja Tysiac's situation who seek first trimester abortions to avoid serious health risks.[126]

The situation in Mexico City is similar. Within days of the liberalization of Mexico City's abortion law in 2007, low-income women who had previously been barred from legal abortions began coming to public hospitals to access the now-legal procedure through the nation's public health scheme.[127] One year after the change in the law, more than 12,000 women had received legal abortions, many at public hospitals where the government funded the procedure.[128]

Colombia likewise has a well-developed national health care system.[129] A government regulation issued in the wake of the 2006 Colombian Constitutional Court decision made clear that, for poor women, the newly available abortion services would be subsidized by the government.[130]

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125. HUMAN RIGHTS WATCH, *supra* note 85, at 28–29.

126. Girard & Nowicka, *supra* note 95, at 23 (noting a narrow range of legal abortions performed free of charge at public hospitals); Sapp, *supra* note 101; PewForum.org, Abortion Laws Around the World (Sept. 30, 2008), http://pewforum.org/docs/?DocID=167#latinamerica; *see also* Tysiac v. Poland, 45 Eur. Ct. H.R. 42, ¶¶ 114–15 (2007) (noting role of public doctors in providing legal abortions).

127. *Mexican Supreme Court Upholds Mexico City Abortion Law by Overwhelming Majority*, IPAS, Apr. 28, 2008, http://www.ipas.org/Library/News/News_Items/Mexican_Supreme_Court_upholds_Mexico_City_abortion_law_by_overwhelming_majority.aspx.

128. *Id.*

129. Alicia Ely Yamin & Oscar Parra Vera, *The Role of Courts in Defining Health Policy: The Case of the Colombian Constitutional Court* (Harvard Univ. Human Rights Program Working Paper Series, 2008), *available at* http://www.law.harvard.edu/programs/hrp/documents/Yamin_Parra_working_paper.pdf.

130. Ordolis, *supra* note 115, at 276–77. The status of that regulation is unclear at the time of this writing. After nearly three years in force, the regulation was temporarily suspended by the State Council, Colombia's highest administrative court, based on the technical argument that implementation of the Constitutional Court's decision should have been advanced by the legislature rather than the executive. Press Release, Women's

Internationally, the availability of public funding to cover legal abortion procedures is not limited to these recent cases. In Canada, for example, the Supreme Court ruled in *R. v. Morgentaler*[131] in 1988 that a criminal prohibition on abortion violated individual rights under the Canadian Charter of Rights and Freedoms.[132] Since that time, abortion has not been nationally regulated in Canada. Provincial health insurance plans cover the cost of abortions performed in hospitals.[133]

Abortion is also freely available, and publicly supported, in Great Britain. Within the first twenty-four weeks of pregnancy, government-funded abortions may be obtained to save the life of the mother, to protect her physical or mental health, to terminate pregnancies involving fetal abnormality, or for social or economic reasons. In cases in which the mother's life or health is "gravely threatened" or there is significant risk for fetal abnormality, there is no time limit on when an abortion may be performed.[134]

In Germany, a 1975 law made abortion nominally illegal.[135] However, in accordance with judicial decisions on the issue, neither doctors nor women are prosecuted if the mother is a victim of rape and the procedure is performed within twelve weeks of conception.[136] An even broader waiver exists in the first trimester for cases in which the mother has received counseling to encourage carrying her baby to term but still wants an abortion.[137] After the first trimester, abortion is available only to preserve the life or mental or physical health of the mother. For these legal abortions, state insurance generally pays for

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Link Worldwide, Legal Interpretation of the Temporary Suspension of Abortion Regulations (Oct. 20, 2009), http://www.womenslinkworldwide.org/pdf_press/press_release_20091022_en.pdf.

131. [1988] 1 S.C.R. 30 (Can.).

132. *Id.* at 36–37.

133. *Id.*; PewForum.org, *supra* note 126 (select "Canada" from "Country" drop-down menu).

134. PewForum.org, *supra* note 126 (select "Great Britain" from "Country" drop-down menu).

135. Bundesverfassungsgericht [BVerfGE] [federal constitutional court] Feb. 25, 1975, 39 Entscheidungen desBundesverfassungsgerichts [BVerfGE] 1 (F.R.G.), *translated in* John D. Gorby & Robert E. Jonas, *West German Abortion Decision: A Contrast to* Roe v. Wade, 9 J. MARSHALL J. PRAC. & PROC. 605 (1976); Bundesverfassungsgericht [BVerfGE] [federal constitutional court] May 28, 1993, 88 Entscheidungen des Bundesverfassungsgerichts [BVerfGE] 203 (F.R.G.).

136. Bundesverfassungsgericht [BVerfGE] [federal constitutional court] May 28, 1993, 88 Entscheidungen des Bundesverfassungsgerichts [BVerfGE] 203 (F.R.G.).

137. PewForum.org, *supra* note 126 (select "Germany" from "Country" drop-down menu).

the procedure in cases of financial need.[138] In several other countries with national health care plans, including Denmark, Romania, and Finland, an abortion from a public provider is no- or low-cost.[139]

Importantly for purposes of this discussion, in each of these countries, the legalization of abortion through judicial ruling or legislative enactment, whether under international or domestic law, was directly coupled with access to public funding for legal abortions. In a context where a national public health plan was already in place, where the provision of health care was already viewed as a government responsibility, the extension of health care coverage to include newly legal abortion procedures was accomplished largely without fanfare.

CONCLUSION

Just as the United States was, until recently, the only developed nation that eschewed a comprehensive national health care system, so too it appears to be the only nation that so firmly de-links public financial support of low-income women's abortion from the legality of the procedure.[140]

Given the recent debate on inclusion of abortion funding in proposed U.S. health care legislation, it is unlikely that the national health care plan will fundamentally change access to abortion in the short run. Rather, the debate concerned whether abortion funding would be even more restricted under a new regime, with the House of Representatives approving a bill that would constrain insurance companies receiving federal subsidies from using *any* funds to provide insurance covering abortion procedures.[141] As with the status quo, access to abortion would be left entirely to market forces—though the proposed federal Spending Clause restrictions would have been more

138. *Id*.

139. SINGH ET AL., *supra* note 31, at 23.

140. This is perhaps not so remarkable given the United States' outlier status as, until recently, the only industrialized nation without a comprehensive national health care plan. Senator Max Baucus, Call to Action: Health Reform 2009, at iii (2008), *available at* http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf. As Rebecca Cook, Bernard Dickens, and Laura Bliss have observed, as national abortion policies have liberalized, nations with nationally funded health care have had to squarely address the issue of coverage. *See* Rebecca Cook, Bernard Dickens & Laura Bliss, *Health Law Ethics: International Developments in Abortion Law from 1988 to 1998*, 89 AM. J. PUB. HEALTH 579, 580 (1999).

141. *See*, *e.g.*, David D. Kirkpatrick & Robert Pear, *For Abortion Foes, a Victory in Health Care Vote*, N.Y. TIMES, Nov. 8, 2009, at A1, *available at* http://www.nytimes.com/2009/11/09/us/politics/09abortion.html.

restrictive than the current system and could have had the effect of essentially eliminating all private insurance coverage of abortion.[142]

However, while the short-term impact of a national health plan on financial support for low-income women's access to abortion is likely to be minimal at best or even negative, the international cases discussed above suggest that the long-term impact may be the opposite. Even if abortion remains formally outside of the health care system, the context for the abortion debate will change dramatically. Indeed, one of the reasons that health care has moved ahead on the national agenda is because it is increasingly seen by those within the United States as an important human right. According to the Opportunity Agenda, eighty-nine percent of Americans already believe that access to health care is a human right, with seventy-seven percent believing that the national government has responsibility to guarantee access to everyone.[143]

As basic rights to health care are implemented in the United States on a national basis, it seems entirely likely that over time, regardless of the recent pitched debate on the issue, the de-linking of the fundamental right to abortion and *access* to the right will no longer seem so natural to courts or legislatures or even the public. By the same token, to the extent that courts are discouraged from requiring the government to fund abortion for fear of overstepping the bounds of judicial authority, the existence of a comprehensive national health plan should ease those worries. The intrusion on legislative prerogatives required to mandate access and public funding, particularly for therapeutic abortion, may no longer seem beyond the scope of judicial authority when the legislature has already endorsed comprehensive health coverage. Under the new scheme, in fact, a new avenue would open for exchanges between courts and legislatures on the scope of public health funding and the fundamental meaning and practical purpose of the right to an abortion.

This observation circles back to the initial questions raised in this Article about the framing of abortion rights. Just as domestic pro-choice advocacy groups anticipated some time ago when they

142. Rita Henley Jensen, *Democrats' Health Bill Victory Tramples Choice*, WOMEN'S E-NEWS, Nov. 9, 2009, http://www.womensenews.org/story/health/091108/democrats-health-bill-victory-tramples-choice.

143. OpportunityAgenda.org, Health as a Human Right: Promoting Equal Access to Quality, Comprehensive Health Care for All, http://opportunityagenda.org/files/field_file/Health%20as%20a%20Human%20Right.pdf (last visited Apr. 19, 2009).

broadened their missions to explicitly situate abortion as a part of a broader range of health care work, the central question is, "is abortion health care?" Interestingly, the conservative *Washington Times* asked just that question in a 2009 article on the health care debate concerning abortion coverage.[144] One could refine the question by asking more pointedly, "are therapeutic abortions"—those abortions performed for the purpose of protecting a woman's health—"health care?"

The answer in virtually every nation with a health care system and where at least some abortions are legal is "yes," particularly with respect to therapeutic abortions which are, by definition, necessary to preserve the mother's life or health. In those countries where therapeutic abortions are recognized as health care under a national health care scheme, public funding is provided to low-income women—and in some instances to others—to ensure their access to their exercise of their fundamental rights.[145]

These international approaches rest on the recognition that the private market is ineffective to adequately protect women's right to access abortion services. Even though abortion has been ostensibly excluded from the national health care scheme enacted in the United States, the recognition of health care as a fundamental human right that such a scheme entails seems likely to trigger the eventual recognition of therapeutic abortion as health care and as a right that deserves similar protection from the exigencies and inequities of market forces.

144. Charmaine Yoest, *Is Abortion Health Care or Is It Not? This Existential Question Is Precisely the Debate We Confront*, WASH. TIMES, Sept. 21, 2009, http://www.washingtontimes.com/news/2009/sep/21/is-abortion-health-care-or-is-it-not/.

145. *See supra* notes 125–39 and accompanying text.