ELSEVIER

Contraception xx (2016) xxx–xxx

Contraception

Original research article

Public funding for abortion where broadly legal☆,☆☆,★

Daniel Grossman[a,b,*], Kate Grindlay[c], Bridgit Burns[c]

[a]Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California San Francisco, 1330 Broadway, Suite 1100, Oakland, CA, 94612, USA

[b]Ibis Reproductive Health, 1330 Broadway, Suite 1100, Oakland, CA, 94612, USA

[c]Ibis Reproductive Health, 17 Dunster Street, Suite 201, Cambridge, MA, 02138, USA

Received 22 January 2016; revised 24 June 2016; accepted 27 June 2016

Abstract

Objective: The objective was to investigate public funding policies for abortion in countries with liberal or liberally interpreted laws (defined as permitting abortion for economic or social reasons or upon request).

Study design: In May 2011–February 2012 and June 2013–December 2014, we researched online resources and conducted an email-based survey among reproductive health experts to determine countries' public funding policies for abortion. We categorized countries as follows: full funding for abortion (provided for free at government facilities, covered under state-funded health insurance); partial funding (partially covered by the government, covered for certain populations based on income or nonincome criteria, or less expensive in public facilities); funding for exceptional cases (rape/incest/fetal impairment, health/life of the woman or other limited cases) and no public funding.

Results: We obtained data for all 80 countries meeting inclusion criteria. Among the world's female population aged 15–49 in countries with liberal/liberally interpreted abortion laws, 46% lived in countries with full funding for abortion (34 countries), 41% lived in countries with partial funding (25 countries), and 13% lived in countries with no funding or funding for exceptional cases only (21 countries). Thirty-one of 40 high-income countries provided full funding for abortion (n=20) or partial funding (n=11); 28 of 40 low- to middle-income countries provided full (n=14) or partial funding for abortion (n=14). Of those countries that did not provide public funding for abortion, most provided full coverage of maternity care.

Conclusion: Nearly half of countries with liberal/liberally interpreted abortion laws had public funding for abortion, including most countries that liberalized their abortion law in the past 20 years. Outliers remain, however, including among developed countries where access to abortion may be limited due to affordability.

Implications: Since cost of services affects access, country policies regarding public funding for services should be monitored, and advocacy should prioritize ensuring the affordability of care for low-income women.

Keywords: Abortion; Public funding; Cost; Global

1. Introduction

Worldwide, unsafe abortion accounts for 8%–18% of maternal mortality,[1] resulting in as many as 44,000 deaths annually and considerable morbidity that impacts women's well-being, quality of life and productivity, and also has a significant impact on families and communities [1–4]. Between 1995 and 2008, the proportion of abortions that were unsafe increased from 44% to 49%, and the vast majority occurred in developing countries [5]. A recent analysis found that the abortion rate has decreased significantly in developed countries, while it has remained constant in developing countries [6]. Denying women access to safe abortion not only threatens women's and families' health and well-being, it is also increasingly recognized as a violation of women's human rights [7].

Legal restrictions on abortion are associated with increased rates of unsafe abortion, and data from several

☆ Conflicts of interest: none.

☆☆ Role of the funding source: The study was funded by grants from the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and an anonymous foundation.

★ These funders played no role in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication.

* Corresponding author. Tel.: +1 510 986 8941; fax: +1 510 986 8960.
E-mail address: Daniel.Grossman@ucsf.edu (D. Grossman).

[1] Up to 42 days after termination of pregnancy.

http://dx.doi.org/10.1016/j.contraception.2016.06.019
0010-7824/

countries such as Romania and South Africa indicate that liberalization of the abortion law has been associated with a reduction in maternal mortality [8,9]. In sub-Saharan Africa and Latin America, unsafe abortion constitutes a higher proportion of maternal mortality than other regions with less restrictive laws [2]. However, this correlation is imperfect, and some countries, such as India and South Africa, have high rates of unsafe abortion despite a permissive law [5,10,11]. Although abortion has been legal since 1973 in the United States, unsafe self-induced abortion has also been reported there, especially among immigrant women [12,13].

Even where abortion is legal, women may face barriers to access to safe abortion, including the high cost of the procedure. An analysis in the United States found that the median cost of a first-trimester abortion was almost twice the typical annual out-of-pocket health care expenses paid by young, uninsured individuals [14]. Women attempting to self-induce abortion in the United States cited the high cost of the procedure in a clinic as one of the motivating factors in their decision [13]. In India, informal payments to hospital staff have been highlighted as an obstacle to safe services, especially for adolescents [15].

Despite the evidence that cost may create a barrier to access, public insurance coverage of abortion, as well as inclusion of the service in health sector reform, has been controversial in some countries, including the United States and Switzerland [14,16]. We aimed to document government policies on public funding for abortion in countries where the procedure is broadly legal and to explore regional and temporal patterns in such coverage.

2. Material and methods

We collected data for this analysis in two rounds: May 2011–February 2012 and June 2013–December 2014. All data presented are from the second round except for Bahrain and North Korea, for which the data were collected in the first round and we were unable to update in the second round. We conducted an email survey to determine the public funding policies of countries with liberal or liberally interpreted abortion laws. We included countries if they permitted abortion for economic or social reasons or upon request by law [5,17]. We also included Mexico's Federal District (Mexico City), where the abortion law is liberal and services are available upon request [5]. Additionally, we included countries that liberally interpret physical or mental health indications, including Bangladesh (under menstrual regulation) [18], Ethiopia [5], Ghana [19,20], Hong Kong [5], Israel [5], Mozambique [21], New Zealand [5] and South Korea [5].

We sent a brief email survey with questions about publicly available information to ministries of health, family planning associations, health care centers, physicians, and other reproductive health practitioners with country expertise. The questionnaire asked whether abortion was generally paid for by the government in the country and, if not, how much a woman would typically pay for a first-trimester abortion; if there was a public health system that paid for most health care in the country; if maternity care, including prenatal care and delivery services, was generally paid for by the government and if there was published information related to public funding for abortion. We gathered additional information related to funding policies from reviews of country abortion legislation, peer-reviewed articles, government documents and other online resources. In cases of data discrepancies between different sources for the same country, we reached out to respondents for clarification and resolution.

We analyzed the survey responses and resources, and categorized countries by the degree to which they used public funding for abortion services, as follows: (a) full funding for abortion (including if abortion was provided for free at government facilities and/or covered under state-funded health insurance); (b) partial funding for abortion (including if the government subsidized part of the cost, the government funded abortion for certain segments of the population only based on income or nonincome criteria (i.e., marital status or age) and/or abortion was less expensive at public compared to private facilities); (c) funding for exceptional cases (including, but not limited to, rape/incest/fetal impairment and for the health/life of the woman, or in very limited cases such as physical or mental disability) and (d) no public funding. We also categorized each country as having full, partial or no public funding for maternity services (including prenatal care and delivery) and for general health care. Because many public insurance programs have income inclusion criteria, such as the Medicaid program for low-income people in the United States, we classified national health insurance programs that covered low-income people without cost as full funding. For example, if a country had a national compulsory private health insurance program or a national health insurance that was paid for through taxation or individual and employer contributions, and the program was free for low-income people, the program would be classified as full funding; if this insurance program covered abortion care and/or maternity care, we classified these services as having full funding. For countries without full funding for abortion, we compared the policy to that of maternity services.

We used 2016 population estimates [22] to calculate the proportion of women aged 15–49 living in countries that had full funding, partial funding and no public funding for abortion among those who lived in countries with liberal or liberally interpreted abortion laws. We also explored the relationship between public funding for abortion and country income status using the 2016 World Bank country classifications of low or middle income, and high income [23].

3. Results

We obtained data for all 80 countries that met our inclusion criteria. Among the world's female population aged 15–49 residing in countries with liberal or liberally interpreted abortion laws, 46% lived in countries with full funding for abortion (34 countries), 41% lived in countries