Access, the Best Birth *Control*: An Issue of Justice

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Abstract: Low-income women face barriers when trying to access family planning services. Notable barriers to accessing family planning services include financial constraints, transportation difficulties, and lack of family planning service providers. I draw on Norman Daniels and Loretta Ross to argue that low-income women's lack of access to family planning services is unjust. I focus on contraception and abortion services, and explore how current policies and practices promote injustice.

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Introduction

"Abortion clinic closed in Birmingham". These were the words that Kew, a 22 year old rising senior in college, saw when conducting a web search after attempting to call two disconnected numbers that once connected women to an abortion clinic in Birmingham, AL. Along with attending school, Kew works at Wal-Mart where she makes a little more than $8 an hour—a wage that she does not believe she will be able to raise a child on. Upon hearing of the closing of Birmingham's only abortion clinic Kew reacted with a single word, "Seriously?" Many other women across the United States, especially in the Deep South, experience similar difficulties when trying to access abortion services. Over the past few decades, the number of clinics providing abortive services has reduced to single digits in many southern states including North Carolina, Tennessee, Arkansas, Louisiana, South Carolina, Mississippi, and Alabama. As of July 2014, there was only one abortion clinic in Mississippi, three in Alabama, and five in Louisiana. (The article notes that three of the five clinics offering abortion services in Louisiana might close in the near future due to their inability to meet regulations.) Closing of abortion clinics in these areas require women to travel further, pay more money for, and receive later-term abortions. For Kew, this meant driving three hours to Columbus, Georgia to get an abortion. When asked about it she said, "All the way from Birmingham to Georgia just to get an abortion, in a way you are trying to control someone's life when you take away those options" (Cleek, 2014). Kew's use of words raises controversial, yet important questions about the state of women's reproductive health care including the novel question of what does justice require in terms of women's reproductive health care? Is it just for women to have to travel hundreds of miles to receive abortive services? Further, what does justice require of other family planning

services? The purpose of this paper is to consider if current women's reproductive health care services, specifically family planning services, are just.

Reproductive Health: Family Planning Services

The World Health Organization (WHO) defines reproductive health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (Reproductive Health). Adhering to this framework, I deduce that reproductive health implies that individuals are "able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so" (Reproductive Health). Access to family planning services is essential to fulfill women's reproductive health needs, as defined by the WHO. While it is important to note that access to all reproductive health care services is essential in order to provide the most comprehensive care to women, my paper will focus on family planning services in particular. The aim of my paper is to focus on low-income women's access to family planning services and how the current lack of access to services negatively impact low-income women of the reproductive age (15-44 years) (Women's health). Although there are numerous family planning services, I focus on access to contraceptive and abortion services. These family planning services have the common aim of preventing unwanted pregnancy. Some may argue that justice also requires allowing low-income women to receive assisted reproductive technologies (ART) if they wish to have children but cannot. I agree that this is a valid argument but it beyond the scope of this paper.

Moral Significance of Access to Family Planning Services

As I come to argue, low-income women lack adequate access to quality family planning services. While most people would consider this predicament to be unfortunate, the question

remains as to whether or not lack of family planning services available to low-income women can be considered an injustice, or is it simply a matter of bad luck? Further, if the lack of family planning services available to low-income women is an injustice, what does justice require to remedy this problem? In order to attempt to answer these questions, I draw on Loretta Ross's reproductive justice framework, which is based on a human rights approach, and Norman Daniels Rawlsian-based theory of justice.

Reproductive Justice: A Human Rights Approach

If I were to ask individuals on the street if they believed health was important to one's well-being, it is plausible the majority of people would agree. That is because in today's society, the importance of health is emphasized. Individuals are urged to get cancer screenings regularly, to visit the dentist, to get immunizations, and a multitude of other health services. Further, the media urges people to live healthy lifestyles that consist of eating a balanced diet and exercising. There is no doubt that society's emphasis on wholesome lifestyles encourages individuals to value health. If individuals value health and seek to get regular mammograms and stay up to date on immunizations, it seems that individuals would value all aspects of health, yet some individuals are opposed to family planning services. Why does this disconnect exist? Perhaps, it is because individuals selectively choose what they believe benefits one's health. If one is to view health as a whole, it is important to identify all services that impact health; one such service is family planning. Family planning services promote health. Janet Museveni, Uganda's First Lady, commented on family planning's relation to health when she said, "Family planning is to maternal health what immunization is to child health" (Cohen, 2010). One way in which family planning services promote [maternal] health is through decreasing maternal mortality rates. Family planning services, such as contraception, allow at-risk women to delay pregnancy.

Further, family planning services, specifically condom use, promotes health for both males and females by providing dual protection against both unintended pregnancy and sexually transmitted infections (STIs) (Pazol, Kramer, & Hogue, 2010). I have illustrated a few of many ways family planning services promote health. By acknowledging the relationship it is then plausible to conclude that an individual who is interested in promoting health is interested in ensuring access to family planning services.

If one sees the benefit of health, which is promoted by family planning services, then they will understand the rationale behind Loretta Ross's reproductive justice model. The reproductive justice model evolved from shortcomings in the reproductive rights model. According to the WHO reproductive rights is "the basic right of all couples and individuals to decide freely and responsibility the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" (Chrisler, 2014). The idea of reproductive rights is based off the principle of human rights and, therefore, includes the right to make decisions regarding reproduction without coercion, discrimination, or violence. While the reproductive rights model adheres to basic rights principles and seems to promote health, it fails to consider structural inequalities that may prevent women from controlling their environment, as it is based primarily on a legal basis (Chrisler, 2012).

I argue that justice requires women to have control over their bodies. In order for family planning services to be considered just, they must not only provide access to services but also education about available services. Providing both access and educational resources about family planning services allows for individual autonomy. How can we say something is just if an individual has no control over outcomes that effect their life? In order for family planning

services to be considered just, individuals must be able to make an informed decision about what is best for them. Looking back at the example of Kew, we can argue that she lacked control of her future. She suggests that institutions tried to control her health outcomes. Kew had reproductive rights because she had the option of driving to Columbus, Ga and paying well $420 for an abortion but did she have reproductive justice? No. An advocate of the alternate reproductive justice model, Loretta Ross, illustrates the shortcomings of the reproductive rights model when she says, "Our ability to control our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice in the United States "(Chrisler, 2014). Ross suggests that the framework of reproductive rights assumes that all women can decide whether and when they want to have children. In reality, this assumption is incorrect. Factors such, as a women's ability to afford or seek out medical services is not readily available to all women.

While the reproductive rights model focuses primarily on ensuring legal rights for individuals, the reproductive justice model aims to align reproductive rights with social justice (Chrisler, 2012). Reproductive justice is the "complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Reproductive Justice). Reproductive justice is only achieved when "women and girls have the economic, social and political power and resources to make healthy decisions about their bodies, sexuality, and reproduction for themselves, their families, and communities in all areas of their lives" (Reproductive Justice). Since reproductive justice seeks to move past a legal standpoint towards incorporating economic, social, and health factors into the analysis of shortcomings in women's reproduction issues, my interpretation is that reproductive justice cannot exist without the presence of reproductive rights (Sanger, 2004).

Reproductive rights are the bare minimum required by law. Reproductive justice requires more than the bare minimum. Rather, social determinants need to be taken into consideration. Advocates of reproductive justice maintain that reproductive justice is only achieved when all women of all races and income levels have equal rights to have a child, to not have a child, to parent the children we have, and to control birthing options (Ross). By comparing the reproductive rights and reproductive justice framework, we see that reproductive justice incorporates a human rights approach advocated by the reproductive rights framework but also goes a step further and analyzes how resources effect a woman's ability to choose her reproductive health outcomes. Thus, in order for family planning services to be considered just, women must have ample choice of family planning services they need. While my analysis of what justice requires from family planning services does not entirely disregard the reproductive rights movement, I rely heavily on the aspect of choice and factors that influence choice outlined in Loretta Ross's reproductive justice framework. Further, I add that educational information about family planning services is necessary to ensure that low-income women can make informed choices.

Opportunity-Based Arguments:

Some would argue that access to family planning services is not a basic human right. If one does not agree with the human rights argument perhaps they would be intrigued by an opportunity-based argument. John Rawls proposed the theory of justice as fairness. Rawls theory of justice as fairness aims to solve the problem of distributive justice, which is characterized by the socially just distribution of goods in a society. Rawls argues that justice requires that all people be treated as free and equal citizens. Rawls proposed the theory of justice as fairness after rejecting the utilitarian argument that suggests that societies should pursue the greatest good for

the greatest number. Further, he rejected the idea that people have an intuit sense of what is morally right and wrong and he argued that situational circumstances can cloud one's moral intuition. In order to determine what a just society looks like, Rawls proposed that individuals decide principles of justice behind a veil of ignorance. Behind the veil of ignorance, individuals are unaware of their own characteristics and thus have no reason not to agree to anything less than an equal share (Coogan, 2007). Rawls acknowledges that injustices exist suggests that people can effectively determine if something is just or not behind the veil of ignorance. Rawls explains the rationale behind the veil of justice when he writes, "Everyone has similar rights and duties, and income and wealth are evenly shared. This state of affairs provides a benchmark for judging improvements. If certain inequalities of wealth and organizational power would make everyone better off than in this hypothetical starting position, then they accord with the general conception" (Rawls, 1971). Behind the veil of ignorance, individuals are charged with determining the just distribution of primary goods in society and agree to two principles of justice. The first principle requires that basic liberties of all citizens be protected. The second principle requires that social and economic inequalities must adhere to fair equality of opportunity (FEO) and the difference principle. Fair equality of opportunity requires that individuals with the same talents and willingness to have the same opportunities regardless of their income status (Wenar, 2008). Rawls writes, "In all parts of society there are to be roughly the same prospects of culture and achievement for those similarly motivated and endowed" (Rawls & Kelly, 2001). The difference principle suggests that justice requires any inequality in the distribution of wealth to benefit individuals who are the worst off (Rawls, the Difference Principle, and Equality of Opportunity). Behind the veil of ignorance, individuals make decisions

about what constitutes justice by determining what would make them content regardless of the final position they end up in.

Norman Daniels, author of *Just Health: Meeting Health Needs Fairly* takes Rawls argument of the relationship between fair equality of opportunity and justice and extends it to health. Daniels claims that health, defined as "normal functioning", is required to promote fair equality of opportunity (FEO). Fair equality of opportunity can be thought of as a leveled playing field. Similar to Rawls, Daniels believes that fair equality of opportunity is required for justice (Daniels, 2008). Daniels extends Rawls argument when he suggests that social determinants of health, such as ability to access a doctor, promote justice. This is the case because social determinants of health impact one's ability to have normal functioning, health.

While Daniels does not specifically mention reproductive health or family planning services his ideas of health can be generalized to fit what justice requires of family planning services. Daniels approach suggests that in order for justice, one must not only have reproductive health but also social determinants of health must be accounted for. In other words, Daniels suggests that factors such as access to a doctor impact one's health which in turn effects fair equality of opportunity and ultimately influences justice. Therefore, in terms of family planning services, Daniels, and I, would argue that in order for there to be justice, an individual must have access to family planning services. Later on in this paper we will see that the current health care system limits a low-income individual's ability to access family planning services because barriers to access such as financial constraints, transportation barriers, and lack of health care providers exist.

While Ross and Daniels definitions of justice differ, similarities can be drawn. Ross uses a human rights approach emphasizing the importance of social justices and women's control over choices that affect their reproductive health. On the other hand, Daniels approaches justice

from an opportunity standpoint and suggests that fair equality of opportunity, which requires health, is necessary for justice. Both theorists highlight the importance of social determinants of health yet approach them from different perspectives. While both theorists would agree that access to family planning services is required for justice, Ross argues that justice requires that individuals not only have access to family planning services but that they also have power in the decision making process, which I refer to as choice. By combining Daniels and Ross's arguments for justice I am able to analyze current family planning services and see if they are just. When analyzing current contraception and abortion services, I argue that justice requires access to services—advocated by Ross and Daniels—and add that justice requires access to information about available services. I add this stipulation to my theory of justice because I believe that women must have information about all available services in order to make an informed decision about what choices are best for them.

Barriers to Accessing Family Planning Services

Within the parameters of Daniels and Ross's theories of justice, it is agreed that justice requires all women to have access to reproductive health care services, including family planning services, regardless of income level. Barriers exist which prevent low-income individuals from receiving adequate family planning services. While it is often assumed that an individual's lack of access to family planning services is due to a lack of adequate income it is important to acknowledge that other social determinants influence one's ability to receive adequate reproductive health services. Barriers to reproductive health care services for low-income women include financial constraints, transportation difficulties, and limited health care supply. By defining barriers to accessing family planning services we are then able to analyze the barriers and determine if they pose a threat to justice deserved by all women, regardless of income.

Financial Constraints

Financial constraints serve as a prominent barrier for low-income women attempting to receive family planning services. Since cost is closely intertwined with other barriers to access that I will discuss later, I limit this section to analyzing how access to health insurance impacts one's ability to access family planning services. Further, I will analyze how financial circumstances affect low-income women's ability to receive health insurance.

ACA and Family Planning Services:

In past years, individuals who were considered impoverished rarely were able to afford health insurance. In 2010, the Affordable Care Act (ACA) was passed in hopes to expand access to quality health care by providing low-income individuals access to health insurance through the health insurance market place while also expanding Medicaid eligibility to cover adults under 65 with incomes up to 133% of the federal poverty line (FPL) (As of January 2015 the poverty level threshold for a household of one was set at $11,770 (2015 Poverty Guidelines)). Along with increasing access to insurance for many individuals, the ACA includes provisions for what is required to be covered under new health insurance plans. Under the ACA, comprehensive coverage for women's preventative care is required. Under the ACA all insurance plans are required to cover contraceptive methods and contraceptive counseling without any cost sharing. (Affordable Care Act Rules on Expanding Access to Preventive Services for Women, 2013). (The guidelines concerning contraceptive methods and counseling do not apply to women who are participants or beneficiaries in health plans sponsored by religious employers.) The ACA does not require coverage for abortion services, a topic to be discussed later in this paper.

While the ACA aimss to provide insurance to low-income individuals, loopholes exist which deny many low-income individuals coverage. This is a result of a 2012 Supreme Court

ruling, which decided that the decision to expand Medicaid is left to the individual state. Since then, only 28 states have expanded Medicaid while 7 states are discussing it (Figure 1) (Garfield et. al., 2014). The implication of this is that without Medicaid expansion, many low-income individuals fall into the “Medicaid coverage gap”. In other words, some individuals in states who have not yet expanded Medicaid are not poor enough to qualify for Medicaid but do not have a high enough income to qualify for federal marketplace subsidies which are available to individuals with an income 100-400% above the FPL (Figure 2). This Medicaid coverage gap exists because Medicaid was originally supposed to cover individuals with incomes below 133% of the federal poverty line. While some states have expanded Medicaid to individuals who have incomes below 133% of the federal poverty line,

Current Status of State Medicaid Expansion Decisions

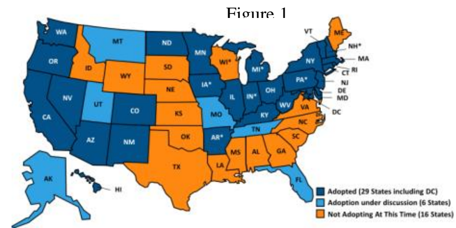

Figure 1

other states have kept previous Medicaid eligibility levels as low as 18% of the federal poverty line. Further, many states that did not expand Medicaid exclude non-disabled individuals without dependent children from qualifying for Medicaid. This is devastating because individuals without children are often in need of family planning services. States expanding Medicaid provide its services to individuals without children who are up to 133% above the federal poverty line (Garfield et. al., 2014).

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.

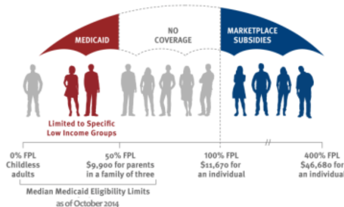

Figure 2

Although many low-income individuals rely on Medicaid as a health safety net, individuals in states that have not expanded Medicaid are not able to access this safety net because they do not meet eligibility requirements. Prior to the passing of the ACA, the Kaiser Foundation found that 20% or 19 million women ages 18-64 were uninsured. 53% of that population had an income below 138% of the FPL (Health Reform, 2013). What does this mean

in terms of coverage after the passing of the ACA? Potentially, 53% of women fall into the Medicaid coverage gap and therefore possibly lack insurance due to states not expanding Medicaid coverage. As of October 2014, an estimated 4 million individuals were stuck in the Medicaid coverage gap. If we look closer at the data, it is seen that 86% of individuals in the coverage gap are located in the south. Further, 83% of the population in the coverage gap is of reproductive age (Garfield, Damico, Stephens, & Rouhani, 2014). The argument above depicts the harsh reality that while the Affordable Care Act has increased access to care for some low-income individuals it is not all encompassing and therefore has not erased disparities in reproductive health care access, especially for those without children who are in need of family planning services.

Through analyzing the shortcomings of the ACA, I have demonstrated that an individual's financial situation can impact whether or not they have affordable access to a health care provider. While health insurance does not guarantee that one will have transportation to doctors providing family planning services, or that they will be able to find a health care provider with availability, insurance provides low-income individuals with coverage for contraceptives and contraceptive counseling with no cost-sharing. The downside is that currently not all low-income individuals are able to receive insurance through Medicaid. Specifically, we see geographical disparities in Medicaid expansion as disadvantaged as 86% of individuals in the coverage gap are located in the south. The looming question is why does this disparity exist and on a more ethical level, is it just that geographical location influences one's ability to obtain health insurance? As we will see in later sections of this paper, it is not a coincidence that disparities exist in the Deep South. Rather, these disparities are often a result of deliberate government regulations.

Transportation Issues

Along with lack of adequate health insurance coverage, transportation barriers often serve as an obstacle to accessing family planning services. In order to illustrate transportation issues, I am going to assume that individuals who face barriers accessing a general health care provider also face barriers when seeking out family planning services.

Vehicle access impacts the likelihood of an individual to visit a health care provider. A study by Arcury et al. (2005) surveyed 1,059 individuals from rural Appalachia. They found that individuals who knew someone who reliably provided them rides visited health care professionals more than individuals who did not have a reliable source of transportation. Silver et al. (2012) also studied the correlation between utilization of health care providers and vehicle access. The study surveyed 698 low-income adults and found that 25% of missed appointments or rescheduling of appointments resulted because of transportation issues. Further, the study found that individuals who used the bus as a means of transportation were twice as likely to miss their appointments compared to individuals who had access to a car. Further, a study looked at 64 rural HIV-infected women and found that 31% of the subjects were lacking transportation and 37% were missing appointments due to transportation barriers (Sarnquist et al., 2011).

Proximity to a provider also impacts likelihood of an individual to visit a health care provider. A study found that rural individuals report more transportation barriers due to increased distance to a health care provider than urban individuals (Probst et al., 2007). A separate study directly asked individuals if distance is a barrier to health care access and found an overwhelming number of individuals answered yes (Okoro et al., 2005). Related to transportation issues, I found studies that analyzed transportation's relationship on likelihood to refill prescriptions—a topic of interest, since some contraceptives require individuals to obtain

refills from pharmacies. A notable study related to this topic examined 84 adults living in urban Atlanta and found that patients who reported that they had difficulty visiting the pharmacy filled their prescription less than those who did not report difficulty visiting a pharmacy. Further, 65% of the individuals argued that transportation assistance would allow them to use their medication more consistently (Kripalini et al, 2008).

While the studies I analyzed do not directly look at the effects of transportation on the likelihood of a low-income woman to access a health care provider for family planning services, it can be deduced that transportation issues affect access to qualified health care providers in general. Further, the studies indicate that individuals living in a rural area, which account for much of the Deep South, deal with extenuating transportation constraints. Transportation issues serves as a major barrier to access of family planning services and this issue will be referenced throughout the remainder of this paper.

Coverage Does Not Mean Access

Previously, I illustrated how differential expectations between federal and state governments have resulted in numerous low-income women being caught in the Medicaid coverage gap. While this is an issue, barriers to access also arise for low-income women who do have Medicaid or Marketplace insurance coverage, yet cannot access a doctor due to lack of availability. It is estimated that approximately 6.7 million Americans gained insurance through the Affordable Care Act. The increase in the number of uninsured individuals led to a flooding of the primary care system and there not enough doctors to meet the demand (Kennedy, 2014). This leaves some individuals in a predicament where they have insurance yet no doctor to see (Figure

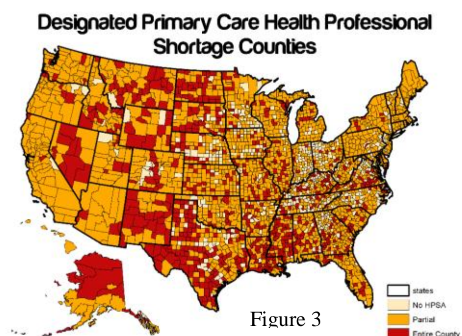

Figure 3

3). The ACA is attempting to remedy doctor shortages and lack of doctors accepting Medicaid patients by providing incentives to doctors and by creating training programs. Currently the ACA and other federal investments are contributing money towards training new primary care providers (Creating Health Care Jobs, 2015). The ACA is also creating primary care payment incentives in hopes to get doctors to accept more Medicaid patients. Incentives include a ten percent Medicare payment increase. While the ACA is attempting to remedy the doctor shortage, many doctors are still reluctant to serve Medicaid patients due to the low reimbursement rate. The ACA enticed doctors to serve more Medicaid patients by increasing the Medicaid reimbursement rate to match Medicare's reimbursement rate that is about 80% of what private insurance pays (Creating Health Care Jobs, 2015). Unfortunately, the provision was only in effect for two years and as of 2015 the Medicaid reimbursement rate is back down to 56% of what private insurance pays (Matthews, 2015). An implication of this is that the doctor shortage may get worse in coming years. In order to increase the supply of doctors willing to treat Medicaid patients, Medicaid reimbursement rates need to match private insurance reimbursement rates.

After analyzing three main barriers to access: transportation, income, and health care supply, it can be concluded that disparities in access to health care overwhelmingly affect the low-income population. Further, data suggests that individuals located in the Deep South are disadvantaged more than individuals located in other areas of the United States. Whether barriers result from financial constraints, transportation issues, or lack of health care providers is a trivial matter. Rather, the important fact to note is that low- income individuals in the Deep South or other predominantly rural areas have less access to health services than others. Based on this evidence, we can assume that low-income women have less access to family planning services.

The following section will explore family planning services available to low-income women in the Deep South and determine if adequate services are available. Further, if it proves true that disparities in ability to access health care does affect woman's ability to access family planning services, it is necessary to question if this is just. In other words, would it be correct to say that expanding the ACA to provide insurance to only some of the low-income population is sufficient for justice? Or rather, does justice require that all, not just some, of the low-income population benefit from the ACA? Lastly, we must determine if justice requires that all family planning services, including abortion services, be covered under ACA provisions targeted at women's reproductive health or if justice only requires coverage of select family planning services.

Analysis of Family Planning Services

Contraceptives

Access to contraceptives is important as it allows for women to control their own fertility (Ferguson, 2009). Contraception allows women flexibility to control when, whether, and how they conceive. This is important for low-income women as they often face financial and emotional hardships that would make the conception of a child hard to handle. Unintended pregnancy is an area of concern because studies have shown that women who have unintended pregnancies are more likely to have poor outcomes including low birth weight, infant mortality, and maternal mortality (Cheng et al., 2009). By utilizing contraceptives, low-income women are able to prevent unwanted pregnancies while also having their reproductive rights and therefore, justice upheld. Some individuals argue that providing contraception services to all individuals, specifically through the ACA's new mandated coverage provision, is expensive. Rather, the opposite is true. Gold et al., found that every dollar invested in helping women prevent unintended pregnancies saves the US government $4.02 in Medicaid expenditures that would

have been used for pregnancy-related care. While providing contraception services to all individuals may seem costly, in the long run it saves the United States money.

Nearly half (49%) of all pregnancies in 2006 were unintended (Finer & Zolna, 2011). Unintended pregnancies usually result from lack of, or incorrect use of, birth control. It is reported that only 5 percent of unintended pregnancies result from women who used birth control consistently (Unintended pregnancies in the United States, 2015). Access to contraceptive methods is important for low-income women because women at or below the FPL are five times more likely to become pregnant by accident (Hall & Dieem, 2013). Further, location may influence one's chance of having an unintended pregnancy. States in the Deep South tend to have higher unintended pregnancy rates than states in other parts of the country (Unintended pregnancies in the United States, 2015). (Figure 4). This may be a result of the increased barriers to access in this area. For instance, we have demonstrated that 86% of the uninsured population resides in the south. Thus, the south may have a higher unintended pregnancy rate because many individuals in the south do not have insurance coverage for contraception services. Moreover, since much of the south is rural and has health provider shortages, individuals who do have insurance may have difficulty accessing a doctor because of transportation issues or because no doctors have availability.

Unintended Pregnancy Rates, by State, in 2010

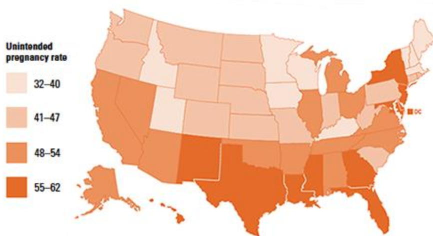

Figure 4

Along with geographical location, income level may influence the rate of unintended pregnancies. Data shows that there are class gaps in unintended childbearing. A study by Reeves and Venator (2015) examined sexual activity level across differing income levels and found that the percentage of women engaging in sexual intercourse was consistent across income groups.

The range of individuals engaging in sexual intercourse was between 65-71% across all income groups. However, when they examined contraceptive use across income groups they found a pattern that indicated that individuals from higher income groups use contraception more than individuals from low-income groups. The study examined pregnancy rates for single women who were not trying to conceive and found that individuals from lower income groups have higher unintended pregnancy rates than individuals from higher income groups. The data from this study suggests that while individuals from all income groups engage in similar amounts of sexual intercourse, individuals from low-income groups use contraceptive methods less frequently and thus have a higher unintended pregnancy rate than individuals from higher income levels. Figure 5 illustrates the differences in unintended pregnancy rates between income groups. Why does this disparity between income-groups exist? Multiple studies have explored this relationship and found that cost is a barrier for using contraceptives (Sonfield & Pollack, 2013). In order to reduce the barrier of cost to accessing contraceptives, the ACA included a provision which requires all insurance plans to cover FDA-approved contraceptive methods and contraceptive counseling without cost-sharing (Affordable Care Act Rules on Expanding Access to Preventive Services for Women, 2013). Inclusion of coverage of contraceptive methods and counseling services in the ACA is a step forward towards providing broader access to family planning services for low-income women but it does not completely fulfill the requirements for justice. While the ACA's provision for covering contraceptive methods and counseling promotes health and provides fair equality of opportunity for some, it fails to promote these essential aspects required for justice for individuals who fall into the Medicaid coverage

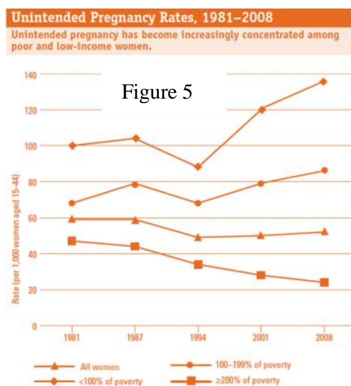

Figure 5

gap. Because an individual's income level predicts whether or not they will qualify for Medicaid coverage, we cannot say that all individuals have access to health and therefore some individuals lack fair equality of opportunity and thus justice.

The ACA's incomprehensiveness is not solely to blame for inadequate family planning services. If the ACA were solely responsible for lack of justice in family planning services, then we would expect that low-income individuals covered under the ACA would have adequate justice but this is not the case because even though covered individuals have health insurance not all utilize these services. Specifically, the Reeves and Vector (2015) study indicates that individuals who have an income that qualifies them to benefit from contraceptive services and counseling do not always utilize these services. This could be because they do not have access to transportation to visit a doctor who provides family planning services or perhaps they do not know these low cost services exist. Building off Loretta Ross's reproductive justice framework, I argue that information and education about family planning services is required for justice. Ross's model of reproductive justice explicitly advocates for the importance of choice and availability of information as Ross states that, individuals must be able to, "decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" (Chrisler, 2014). Likewise, Daniels theory of justice requires both promotion of health and fair equality of opportunity for justice. How can health be promoted fully if individuals are unaware of available contraceptive services or are not given the choice of using the most effective method of contraception? Applying Ross and Daniels and my interpretations of justice allows us to conclude that justice not only requires access to contraceptive services but also information about the availability of services, including effectiveness of varying contraceptive methods.

Along with using contraceptives less frequently than individuals with higher incomes, studies have found that low-income individuals use less effective methods of contraception than their higher income counterparts. A study by Ayoola et al., (2014) surveyed a medically underserved neighborhood and found that low-income individuals do not use the most effective contraceptive possible. They found that of the women who were not trying to get pregnant, only 68.4% of them were using a form of contraception. Of the women who were using a contraceptive to avoid unwanted pregnancy, 32.8% used condoms, a least effective method of contraceptive. 13.5% were using moderately effective contraceptives, which rely on the individual's use to be effective such as an oral pill, vaginal ring, or a patch. 53.7% were using a long acting reversible contraception (LARCs) or injectable, effective methods of birth control that do not depend on the individual's use to be effective. LARCs include intrauterine devices (IUDs) and implants. While these findings indicate that some low-income women utilize effective methods of birth control it also raises the question of why other low-income women rely on less effective birth control methods. Perhaps, individuals do not know about the increased benefits of using a more effective form of birth control. A study conducted in 2010 found that when offered the choice of any birth control method at any cost, two-thirds of the ten thousand women surveyed, chose long acting methods. This number is higher than the current number of individuals using long acting methods (Sonfield & Pollack, 2013). While we have explored the cost barrier it is important to note that perhaps individuals are not aware of the benefits of long acting, effective methods of birth control. Educating individuals of the benefits of long acting contraceptive methods would allow individuals to weigh their options and choose which option best suits their lifestyle. Educational services need to provide information about convenience of methods along with cost information. For example, low-income individuals may not know that

LARCs provide continuous birth control for numerous years. Providing this information would allow individuals to analyze their situations and decide if LARCs are more convenient for them. If an individual has transportation barriers, perhaps they would benefit more from a contraceptive method that does not require monthly trips to the pharmacy. Since justice requires individuals to have access to both family planning services and choice in care, it is important to provide educational information about contraceptive methods along with access to these methods. Along with providing access and information, justice requires that individuals have the final choice in which method suits them best. If an individual is not interested in an implant or LARC after being informed about the increased effectiveness of a LARC and its increased convenience, then the decision to opt out of utilizing the method of birth control must be respected as long as the individual was able to make an informed decision and barriers to access were non-existent.

Are Doctors and Pharmacists Contributing to the Injustice?

Across the nation there have been incidents of doctors and pharmacists denying women access to birth control methods. Kate Williams, a 24 year old from Milwaukee, experienced this reality when she went to her family practitioner and was denied a refill for her prescription birth control pills. The doctor cited that she did not prescribe birth control because she "believed in natural family planning" (Roth, 2004). Unfortunately, this is not uncommon or confined to doctors prescribing birth control. There have been reports of pharmacists refusing to fill prescriptions for birth control and emergency contraceptives. Julee Lacey, 33, was "shocked" when she stopped in to a CVS pharmacy in Fort Worth, Texas and was denied birth control. Lacey, who had refilled her birth control prescription numerous times before at this CVS, cited that she was refused birth control during her visit because the pharmacist "did not believe in birth

control" (Jones, 2004). Refusal to provide contraceptives is also largely experienced when individuals try to access emergency contraceptives such as Plan-B. Lori Boyer utilized emergency room services at a hospital in Lebanon, Pennsylvania after being raped. Boyer was allowed access to a rape kit and sexual assault counseling services but when she asked Dr. Gish for the morning after pill he replied, "No, I can't do that. It's against my religion." These reports make us question whether or not justice requires doctors to provide access to all family planning services even if it goes against their beliefs. Earlier we determined that justice requires access to and information about services yet one in three women do not know about emergency contraceptives. Further, a study done by The New England Journal of Medicine found that 8 percent of providers felt no obligation to present all options to their patients (Erdely, 2007). Is this just? If women access family planning service providers they presume they are receiving all the information needed to make an informed decision yet this is not the case. Withholding information from women prevents them from controlling their health circumstances and compromises fair equality of opportunity, both essential for justice. In order for fair equality of opportunity to be present, all women must be provided with equivalent information about available methods of contraception along with access to contraceptive methods. Moral beliefs cannot serve as an excuse for providers to strip women of justice they deserve. A study done by The New England Journal of Medicine found that 63 percent of doctors report that they think it is acceptable to refuse treatments to patients if they have moral objections to the treatment and 18% reported that they had no obligation to refer patients to another provider if they were unwilling to provide services (Erdely, 2007). Doctors and pharmacists who refuse to prescribe or dispense contraception are denying women of fundamental health services.

Abortion

If low-income women do end up becoming pregnant it is vital to provide them with opportunities to choose whether or not they want to continue with the pregnancy or abort it. Providing choice in this matter is essential because deciding to have a child has vast implications for a woman's life. It is unjust if society attempts to convince women to forgo abortion. Rather, the decision to have an abortion must be left up to affected individuals. Reproductive justice requires women have the opportunity to determine if and when they want to have a child. Further, women must have control over this choice. If justice requires both the opportunity to choose outcomes and power to make this decision, it would make sense that justice requires that women have access to abortive services without unnecessary barriers.

Recall Kew's story. Kew, 22, was enrolled in college and had a minimum wage, full time job when she found out that she was pregnant. After discussing the situation with her mom, Kew decided that in order to finish school and pursue a higher paying career, it would be in *her* best interest to get an abortion. Kew made an informed decision yet when she tried to call the local family planning clinic all she heard was a dial tone—a symbol indicating the recent closing of the clinic. Luckily, Kew had the means to travel 3 hours across state lines to visit a clinic that provided abortion. Although Kew was able to get an abortion in Georgia can we say the situation was just? No!

Kew is not alone. Many low-income women face similar barriers when trying to access abortion services. A study conducted by the New England Journal of Medicine found that low-income women receive fewer abortions than individuals with higher incomes. While only 8.6% of individuals with an income below 100% of the FPL received an abortion in the year prior to the survey, approximately 31.9% of the individuals with an income above 400% of the poverty line had got an abortion (Reeves & Veenetor, 2015). While some people may jump to the

conclusion that the difference in statistics results from low-income individuals desiring to get an abortion less, that does not seem to be the case. Rather, it appears that barriers such as cost and travel distance negatively impact lower income women's access to abortive services. Cost is often a barrier to receiving abortion services because of Hyde's Amendment. Hyde's amendment is a federal law that bans the use of federal funds for abortion unless the pregnancy is a result of rape, incest or endangers a women's life (State Funding of Abortion Under Medicaid, 2015)..

Cost and travel distance are increasingly becoming a more prominent barriers in the Deep South. This is because states are passing Targeted Regulation of Abortion Provider Laws (TRAP). These regulations have no sound medical basis but rather make it burdensome and expensive to get an abortion. There are a multitude of TRAP laws, which vary across states. Prominent TRAP laws include waiting periods between mandated counseling and when an abortion can be performed (30 states), gestational limits on abortion (22 states), structural standards regulations that require abortion clinics to meet ambulatory surgical center codes (25 states), and hospital admitting privileges (8 states, 4 pending litigation) (Targeted Regulation of Abortion Providers, 2015). Many of these trap laws do not improve patient care but rather set high standards that are nearly impossible for providers to meet. For instance, 11 states require facilities to have set hall widths and specific procedure room dimensions. (Figure 6 defines TRAP laws in various states). For some facilities, complying with these standards would require relocating or redesigning their current building. Both options are very costly to the provider. These TRAP laws have resulted in many abortion providers closing their doors. This results in individuals having the travel further to receive abortion services. Increased distance to a provider

Targeted Regulation of Abortion Providers

STATE	REGULATIONS APPLY TO SITES WHERE:*			FACILITY REQUIREMENTS:					CLINICIAN REQUIREMENTS:		
	Surgical Abortion Is Provided		Medication Abortion Is Provided	Structural Standards Equivalent to Those for Surgical Centers	Procedure Room Size Specified	Corridor Width Specified	Maximum Distance to Hospital Specified	Transfer Agreement with Hospital	Requires:		OB/GYN Certification or Eligibility
	Outpatient Clinics	Private Doctor Offices							Hospital Privileges	Hospital Privileges or Alternative Agreement	
Alabama	X	X	X	X		X			§	X	
Arizona	X	X	X	X			30 milesθ		♦	X	
Arkansas	X	X	X	X	X		30 miles			♦	
Connecticut	X			X							
Florida	X		X	X						X	
Illinois	X	X		X	X	X	15 miles			X	
Indiana	X		§		X	X	adjacent county			X	
Kansas	§	§	§	§			§		§		
Kentucky	X		X	X				X			
Louisiana	X	X		X	X		§		§	X	
Maryland	X			X							
Michigan	X*		X	X	X	X	30 minutes	X			
Mississippi	X	X	X	X	X	X	30 minutes		§	X	X
Missouri	X*			X		X	15 minutes		X		
Nebraska	X	X	X	X	X			X			
North Carolina	X		X	Xθ		X					
North Dakota							30 miles		X		
Ohio	X			X				X			
Oklahoma	X		X	X	X		§		§	X	
Pennsylvania	X	X		X	X	X		X			
Rhode Island	X	X	X	X							
South Carolina	X	X	X	X		X				X	†
South Dakota	X	X	X	X		X					
Tennessee							adjacent county		X		
Texas	§	§	§	§	§	§	30 miles	§	X		
Utah	X	X	X	X	X		15 minutes		X		
Virginia	X	X	X	X	X	X		X			
Wisconsin	X		X					X	§		
TOTAL	24	13	16	22	11	11	11	7	5	9	1

§ This law is temporarily enjoined pending a final decision in the courts.
♦ Policy takes effect later in 2015.

* In most states, regulations apply to all abortion providers or apply to providers who perform or administer more than a small number of abortions. In Michigan and Missouri, requirements apply only to sites where abortion is the primary service.
† Only an obstetrician/gynecologist may provide abortions after 14 weeks of pregnancy.
θ Applies only to surgical abortions.

Figure 6

makes it so that individuals seeking an abortion have to pay more to receive and abortion since they must consider travel expenses. Further, individuals receiving services in a state with a mandated waiting period may have to take multiple days off work and pay for a hotel if the nearest provider is far away.

TRAP laws have caused many providers throughout the south to close their doors. Texas is one of the states where clinics are feeling the pressure from TRAP laws. In 2013, Texas passed a law, which required doctors who perform abortion to have admitting privileges at a hospital within 30 miles (Feibel, 2014). Complying with this regulation difficult for abortion clinics located in rural areas. Along with requiring admitting privileges, Texas passed a TRAP law that requires regulated hallway widths, locker rooms for physicians, and heating and cooling specifications (Feibel, 2014). After the passing of the TRAP laws in October 2014, only eight out of the original thirty-six facilities in Texas remain open (Texas Abortion Clinic Map, 2014).

Mississippi is facing a similar problem. Currently, there is only one facility in the entire state of Mississippi that offers abortion services. The lone remaining abortion clinic is located in Jackson, MS (Quart, 2013). The lack of facilities providing abortions in Mississippi poses a threat to justice. While the average legal abortion rate in 2011 was 16.9/1000 women, the abortion rate in Mississippi was only 3.7/1000 women (State Facts about Abortion: Mississippi, 2014). This is most likely a result of women not having adequate access to abortion services. Recently, a bill that aimed to increase the waiting period between receiving a required ultra sound and receiving an abortion from 24 hours to 72 hours, failed to pass (Mississippi 72 hour Waiting Period Bill SB 2138, 2015). While this is good news, the 24-hour waiting period still serves as a barrier to individuals who must drive long distances on multiple occasions to receive an abortion. The American College of Obstetricians and Gynecologists are opposed to TRAP

laws. Dr. Hal Lawrence CEO of the American College of Obstetricians and Gynecologists comments, “what those laws do is they limit women’s access and expose women to increased risk by not enabling them to have a procedure near where they live” (Feibel, 2014). Currently, barriers to accessing abortion services are unjust. Justice requires that women have, “the basic right of all couples and individuals to decide freely and responsibility the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health” (Chrisler, 2014). Lack of abortion providers prevents women from deciding freely if they want to have a child or not. Further, choice is required for reproductive justice. If there are limited abortion providers, women do not have choice. Currently, the government’s implementation of TRAP laws is reduces a woman’s ability to choose what method of family planning is best for her. Justice requires access to abortive services.

Policy Implications

The current family planning service health system fails to acknowledge structural inequalities among women of differing income and capability levels that contribute to unequal levels of access to reproductive education and family planning services. Along with other stipulations, I argue that fair equality of opportunity is essential for justice. If fair equality of opportunity is essential for justice, policy implications need to directly address fair equality of opportunity. Although there are a multitude of policy implication I focus on what I believe is the most upstream factor that influences low-income women, Medicaid coverage. Fair equality of opportunity cannot exist unless all individuals benefit. Therefore, I propose Medicaid expansion in all states. Further, I propose that Hyde’s Amendment be repealed. Although the ACA includes provisions for contraception coverage, its failure to cover abortion services is unjust. In order to

have true fair equality of opportunity, all family planning services must be covered. If family planning services are covered for all women then women have more choice in their reproductive health. However, women lose control over their reproductive fate when government regulations such as TRAP laws restrict their choice. Therefore, justice requires that TRAP laws be repealed. Overall, policy must promote women's choice and ensure that women have control over their own body.

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