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by
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Abstract

The postwar expansion of many welfare states has seen 'reproduction going public', the development of social policies making reproduction a public and political concern. Though the phrase 'going public' has been applied most commonly to care work, it also describes the politicisation of needs associated with biological reproduction. The present paper is concerned with one such service, abortion, and what it can tell us about the development of the welfare state. The paper focuses on a particular, 'liberal' type of the welfare state found in countries sharing the combined heritages of the British common law tradition and welfare residualism maintaining the privacy of market and family. This paper explores the interplay of abortion rights, politics and services in the liberal welfare states of Australia, Britain, Canada and the United States. It considers the relationship between liberalism and gender and the distinction between 'body rights' and 'social rights'. The availability of abortion is examined in the light of decommodification and social stratification. Civil and social rights to abortion in each of the countries surveyed have been generated within distinctive political environments, each giving direct representation to gender, religion and professional interest. The form these rights have taken, however, also appears to have been shaped by the ideologies and institutional forms of the broader social policy content.

1 Introduction

Hernes (1987: 51-71) has characterised the postwar expansion of the Scandinavian welfare state as 'reproduction going public', the development of social policies making reproduction a public and political concern. Similar trends, though less pronounced, have been noted in Britain and elsewhere (Finch and Groves, 1983; Ungerson, 1990; Robbins, 1990). Hernes was referring most directly to care work, but her phrase also describes the politicisation of needs associated with biological reproduction. Since the 1960s the welfare state has faced new demands ranging from the support of contraceptive services to the use of advanced technology such as in-vitro fertilisation and surrogate parenthood.

The present paper is concerned with one such service, abortion, and what it can tell us about the development of the welfare state. The paper will explore the interplay of rights, politics and services surrounding abortion in four countries having similarly 'liberal' welfare states. These four are Australia, Britain, Canada and the United States.

These countries have limited welfare states with selective state welfare policies which while assuring a minimum standard of well-being preserve scope for market arrangements above that minimum. Perhaps most importantly for the consideration of abortion, they share the legal heritage of British common law. They also share a common language and similar cultures, though each country also has significant racial and cultural minorities. The political forces active in abortion politics, including medical professions and women's and anti-abortion movements, are aware of and in touch with one another. Given these similarities, one might expect similar development of abortion rights and services in these countries.

There are, however, also some notable differences between them. Important among these is religious culture, Canada having large Catholic constituencies and the United States active traditions of religious fundamentalism. There are also important legal differences, in that the two North American countries have written constitutions affirming the rights of citizenship and traditions of judicial activism in the interpretation of such rights. Finally, the British welfare state is often distinguished from the others by its commitment to social democratic universalism in key sectors

(Taylor-Gooby, 1991). Among these is health care provision, of particular relevance to abortion. In fact the health systems of three of these countries, Australia, Britain and Canada, contain important elements of universalism, while the American system does not. Some of these differences have been important in the way these countries have responded to the abortion issue.

All four countries have seen significant change to abortion law since the late 1960s. Legal changes have gone furthest in North America, where abortion in the first trimester of pregnancy has come to have the status of a right. In all countries, too, the reform, repeal and decriminalisation of abortion has aroused intense engagement of groups both supporting and opposing women's access to abortion. In some countries this politicisation of the abortion question has been turned against the social rights of the welfare state, and the four countries vary substantially in the support available to a woman seeking legal abortion. The examination of these developments provides an opportunity to examine comparatively the interplay between civil, political and social rights in the context of a liberal welfare state.

Two promising streams of work on the welfare state are beginning to converge. One of these is the comparative study of welfare states, in which analysis is moving toward the investigation of qualitatively different forms of 'social policy regime'. The other is the study of gender as a structure underlying welfare politics and provision, in which issues concerning reproduction and the boundaries between public and private life have attracted increasing attention.

The discussion of welfare state types is not new. One may point, for example, to Titmuss' (1974: 23-32) 'models of social policy'. Nor is there consensus about the number of types to be identified or how they are to be derived. There is nonetheless a good deal of practical agreement in the recognition of certain groupings. The 'Scandinavian Model' (Erikson et al., 1987) is widely accepted as distinctive.¹ Almost as widely recognised is a group of 'laissez-faire' or 'liberal' states. State corporatist and state socialist types have also been proposed (Esping-Andersen, 1987), but with less ready agreement.

1 It should be noted, nevertheless, that Ringen (1991) now rejects the notion that the Scandinavian welfare states represent a common type.

This discussion of welfare state types has been given new impetus by Esping-Andersen's *Three Worlds of Welfare Capitalism* (1990), in which he identifies three types of welfare state. Each is formed through a distinctive pattern of political alliances and produces a distinctive pattern of rights and benefits. The 'liberal' type, found mainly in countries of English political heritage, is designed to relieve poverty while preserving and protecting the labour market and the traditional norms of the work ethic. Its limits stem from its origins in the political initiatives of a weak and isolated working class. Benefits are modest, are directed primarily to low income groups and are often means tested. In sharp contrast, the 'corporatist' welfare state, found mainly in Europe, provides high levels of protection to the whole population, relying relatively little on private markets even to 'top up' protection for higher income groups. This type is a product of alliances between conservative forces seeking social and political stability, and serves to maintain differentials of status and income. The third, 'social democratic' type, is typically Scandinavian and is distinguished by commitment to benefit universalism and full-employment policy. These welfare states owe their development to social democratic alliances of the working and middle classes, and combine a high standard of benefits defined by rights of citizenship with a degree of earnings-related inequality in benefit levels (see also Taylor-Gooby, 1991).

Esping-Andersen suggests that welfare state types are also marked by varying policy stances toward the family and the sexual division of labour. While European corporatist regimes tend to favour the maintenance of the traditional family of male breadwinner and dependent spouse, Scandinavian social democratic regimes are designed to secure increasing gender equality in paid and unpaid work. Esping-Andersen makes no comparable statement about the liberal policy regime. Though he clearly considers them important, these observations are relatively undeveloped in his account. Taylor-Gooby (1991: 93) writes not of the family but of conflicts rooted in gender, which in the liberal welfare state he sees as being subsumed into the class conflicts of the market.

However provisional, these ideas clearly link the study of welfare state types with the study of gender and the role of the welfare state in the nexus between production and reproduction. Beginning with Wilson's *Women and the Welfare State* (1977), this literature has focused on the social policy

nexus between the the public world of economy, production, and democratic politics and the private domain of family, reproduction and the micro-politics of the household.

Recently feminist scholarship has begun to draw on the same broad paradigm of citizenship and political mobilisation (Marshall, 1963; Nelson, 1984; Roe, 1987) that informs the work of Esping-Andersen and others. Hernes (1987), for example, suggests that Scandinavian ideas about active participatory democracy, when joined to the existing sexual division of labour, resulted in a dual form of citizenship. Coinciding with the division between production and reproduction, these are the 'citizen-worker' and the 'citizen-mother'. These different forms of citizenship have been associated with different bases of political organisation, with men dominating the corporatist structures of trade union and parliament and women acting through voluntary associations and local government. American feminists (Nelson 1990; Gordon 1992) have similarly linked the 'two track' American welfare state to the gendered politics shaping the introduction of social security. This scholarship also is increasingly comparative, and has lately begun to draw upon the regime concept (Orloff, 1991; Quadagno, 1989; Orloff, O'Connor and Shaver, 1991; Cass, 1992).

Elsewhere (Shaver, 1990) I have attempted to spell out the principal components of gender in a social policy regime in a manner allowing their integration with the wider framework of class politics and welfare state development. I have suggested that the gender regime of the welfare state can be explicated in three dimensions.

Power and legal personhood refers to the legal identities and rights constituted in the liberal democratic state defining the civil and political status of gendered individuals. Rights of legal personhood rest on the separation of state, civil society and family, and are gendered at several levels. Gender figures most overtly in the extent to which men and women are assigned the same or different rights. This is cross-cut, however, by the degree of individuation of the legal self within the family, and particularly of partners within marriage. The welfare state operates within the framework of these rights, and through its benefits and entitlements conditions their effective meaning and content.

Labour refers to the economic relations of patriarchal capitalist society, including the social organisation of domestic work and paid employment. The welfare state is a political intervention in that economic system, decommodifying labour, sustaining worker productivity and modifying the distribution of market incomes. These interventions have a gender as well as a class character, underlying and conditioning the sexual division of labour in public and private spheres.

Cathexis refers to sexuality, fertility and human reproduction. The welfare state plays an important part in the regulation and support of these functions and in shaping the form of the social unit within which they are enacted. To date the literature on the welfare state, and especially the comparative literature, has been little concerned with this third dimension.² Such relative neglect is odd given the centrality of biopolitics in the development of the welfare state since its inception. Historically the welfare state has been actively concerned with birth legitimacy and the moral character of the unwed mother; with natalism, eugenics and the peopling of the nation; with maternal and child health; and with the regulation of homosexuality, incest, contraception, abortion, adoption and wet nursing.

The present paper attempts to place the discussion of these issues in the broader analysis of the welfare state. Using the instance of abortion services, the paper examines the comparative development of the liberal welfare state in the politically contentious area of women's control over their bodies and fertility.

2 Liberalism and Gender

The distinguishing feature of the 'liberal' welfare state is its minimalism of public provision and the relatively large scope retained for the market to determine the well-being of citizens. As a type, the liberal welfare state tends to be highly residual, maintaining selective arrangements for the poor, while other groups are supported through occupational and voluntary arrangements rooted in the market and class society.

² See Carabine (1992) for an attempt to spell out the range of points at which sexuality enters social policy and practice

Taylor-Gooby (1991) notes two important features of the liberal welfare state. Its limitations, deriving from its formation without the achievement of a class alliance, tend to perpetuate a continuing class struggle, but one waged among individuals through the market. He suggests that citizenship demands are instead channeled through the law, as claims to legal rights and legal equality, also as the entitlements of individuals.

The notion of individual rights is quintessentially liberal. At the heart of liberalism lies the proposition that the individual is the rightful possessor of his or her bodily capacities, what Macpherson has termed the ideology of possessive individualism. Macpherson summarises this ideology in seven propositions:

- (i) What makes a man human is freedom from dependence on the wills of others.
- (ii) Freedom from dependence on others means freedom from any relations with others except those relations which the individual enters voluntarily with a view to his own interest.
- (iii) The individual is essentially the proprietor of his own person and capacities, for which he owes nothing to society.
- (iv) Although the individual cannot alienate the whole of his property in his own person, he may alienate his capacity to labour.
- (v) Human society consists of a series of market relations.
- (vi) Since freedom from the wills of others is what makes a man human, each individual's freedom can rightfully be limited only by such obligations and rules as are necessary to secure the same freedom for others.

- (vii) Political society is a human contrivance for the protection of the individual's property in his person and goods, and (therefore) for the maintenance of orderly relations of exchange between individuals regarded as proprietors of themselves. (Macpherson, 1962: 263-4)

While these rights have been most commonly associated with the capacity to work and the institutionalisation of labour markets, there is no necessity for rights to be so limited. The ideology of possessive individualism has a potentially wider reference to men and women as also possessors of their bodily capacities in sexuality and human reproduction. The representation of the individual as having 'reproductive rights' is a claim of precisely this kind.

Issues concerning fertility have long been central to the claims of social movements, and most specifically of women's movements. Contemporary women's movements have phrased these in the language of citizenship, claiming that a woman has the right to control her own body and fertility, and that 'reproductive rights' are essential preconditions for women's full participation in paid employment and public life. These movements have addressed both civil rights to autonomy in the exercise of reproductive functions, and social rights to the support of the welfare state in access to the medical services necessary for the expression of these rights.

The assertion that a woman has the right to control her own body is an unambiguous statement of her proprietorship in her person, and the 'right to choice' an expression of her free will. These claims assume an essential individualism in which the woman properly acts in the pursuit of her own needs and wishes. Her rightful action in self-interest is limited only by the freedom of others to do likewise.

But as Pateman (1988b) has suggested, liberal ideology rests upon unspoken assumptions about gender, marriage and the family which deny women and children the full and equal status of possessive individuals. Pateman argues that the 'fraternal' social contract of civil society is predicated upon the marriage contract of natural society, with male heads of households consenting to political order on behalf of the members of their households. Thus the full rights and freedoms of civil society pertain to adult men and to

the public world of market and state. As heads of household, men retain their natural rights to authority within the private community of the family.

The social contract is a political fiction, of course, and Pateman's version no more nor less 'true' than the metaphors of Hobbes, Locke and Rousseau. Even so her account resonates powerfully with persistent ambiguities in liberal ideology concerning the independent personhood of women and the boundaries between public and private life. Fundamental to these is the exclusion of the family group and domestic life from the society of individualism, self interest and market exchange. The freely contracting individual of the market has no place in the private society of the family, rather marriage and parenthood are characterised as enduring bonds of altruism and mutuality. A strong liberal norm secures the privacy of the family against the intrusion of the state.

Given these contradictory foundations, it is not surprising that liberal social policy is ambivalent in its treatment of women, recognising them as liberal individuals for some purposes and as family members for others. Feminist critiques of the liberal welfare state have identified patterns of gender running through its institutional structures which assume and reinforce the definition of men as primarily breadwinners and women as primarily wives and mothers, economically dependent on husbands or the state (Wilson, 1977; McIntosh, 1988; Baldock and Cass, 1983;). Wilson (1977: 9) described this as the 'state organisation of domestic life'. These patterns have been variously termed 'patriarchal' (Pateman, 1988a) and 'familial' (Hernes, 1987).

The question of reproductive rights raises the question of women's equality in liberal society in particularly acute form, for it pits her claim to equality as a possessive individual against her connectedness to others. The demand for a right to abortion is particularly problematic, for the discourse of rights in turn raises further issues about how her rights are limited by the potential rights of others. Political conflict over the right to abortion has been waged in precisely these terms. The claim to a civil right to abortion has been met by counter claims about the competing rights of the foetus, of a male sexual partner, and of the parents of a pregnant minor. Claims to social rights in support of abortion services have further evoked responses about the moral rights of medical personnel and of taxpayers.

3 Body Rights, Social Rights

Following Marshall (1963), I see 'reproductive rights' as a form of citizenship in which civil, political and social rights are entailed. Writing about England, Marshall saw these forms of right as developing sequentially, civil rights forming the basis upon which political rights were exercised in the pursuit of social rights to a minimum standard of well-being guaranteed through the state. These forms of right were interdependent and held in an unstable equilibrium in the institutions of a democratic-welfare-capitalist society (Taylor-Gooby, 1991). Marshall observed that in the English case equality of citizenship served to support economic inequality. There is no necessary complementarity between the three dimensions of citizenship, and indeed there is acute tension between these forms of right in the case of abortion.

The establishment of a civil right to abortion makes the service legitimate as a legal commodity for trade, subject to the consent of medical authority. In turn civil rights create the basis upon which claims may be made for the state to replace the market with a minimum standard of access to services, a 'social right' to secure an abortion. The importance of civil rights is here twofold, for civil rights also define group interests and solidarities in the expression of political rights. In the case of abortion, the political mobilisation around the recognition of reproductive rights has drawn less upon class than upon medical and other professional interests, religion, morality, and the changing position of women in paid employment and the family. Coming after the formation of the modern welfare state, both civil and social rights to abortion have been the subject of intense political contestation.

In the tradition of British common law abortion is a criminal act, with exceptions provided in specified circumstances. In many countries the direction of legal change has been for these circumstances to be broadened, from the life of the mother to her physical and mental health, to her having become pregnant through rape or incest, and to the expectation of significant foetal abnormality. The effect of these changes is to legalise abortion in accepted circumstances, defining it as a legitimate form of medical treatment. Here the notion of right attaches to abortion only in the sense of a more general right to health care needs as judged by medical authority, and I refer to this as 'medical entitlement' to abortion. In some

countries, however, abortion has been given the status of personal right, attached not to medical need but to the legal personhood of the woman. Her claim to abortion thus rests on her rights as an individual secure from the interference of the state. I refer to such as a 'body right' to abortion.³

Esping-Andersen (1990) argues that the social rights of the welfare state have effects in two dimensions, the decommodification of market goods, paradigmatically labour, and the stratification of the social order, paradigmatically by income level. The consequences of a social right to abortion are of the same kind, but because only indirectly connected to income and employment are of less visible significance.

The decommodification of labour through the welfare state has a significance going beyond its value to the individual worker. For labour in general, an alternative subsistence sets a floor to the wage bargain and facilitates labour's capacity to organise. The decommodification of abortion by its provision free or at low cost is part of the wider decommodification of health care services, and in this general sense makes the citizen more independent of the market economy than would otherwise be the case. But control over her reproductive capacities also affects a woman's ability to function outside the economic dependence of marriage or to limit her dependence within it. Thus a social right to abortion bears upon women's position in the sexual division of labour both in the home and in paid employment. However, the need for abortion occurs only at a point in time, and is experienced as highly personal. Mobilisation around the right to abortion has cut across class and income, linking conservative political forces with others rooted in religion, morality, gender and professional medical interest.

When abortion is legal, a social right to abortion at little or no cost is unlikely to have significant independent effects on social stratification, but the lack of such a right may be expected to compound more general market disadvantage. Social rights are, however, likely to have considerable significance for women's autonomy within marriage and for young women's independence of parental authority. Social rights are thus of great

3 The categories of 'medical entitlement' and 'body right' broadly correspond to Glendon's (1987: 14) more legally oriented categories of 'abortion for cause' and 'elective abortion'.

significance for the individuation of women within the gender order of the family.

4 Body Rights in the Liberal States

Abortion prior to quickening was legal under the British common law in the nineteenth century, but was brought under regulation with the rise of the medical profession by the twentieth (Luker, 1984, ch 2; Ginsburg, 1989, ch. 2). The British *Offences Against the Person Act* of 1861 removed any distinction of foetal age, but in 1929 the *Infant Life (Preservation) Act* opened the way for abortion to preserve the life of the mother. This ground was broadened in the 1938 decision of *R v Bourne*, in which preservation of the life of the mother was extended to include circumstances in which she would be made a 'physical or mental wreck' (Mason, 1990: 101-2). The move to widen the grounds for abortion began in Britain in the 1950s, and began to have effect in all four countries by the late 1960s. The first wave of liberalisation extended the medical grounds under which abortion was permitted to include the physical and mental health of the woman and in some cases also foetal abnormality.

A number of common factors underlay the move to reform abortion laws. Among these were consumption economies which by the 1960s were drawing married women into paid employment. In their different ways both commercial advertising and radical cultural movements emphasised pleasure and autonomy in personal life (Game and Pringle, 1979). Behavioural changes included more widespread non-marital sex and a reshaping of the life cycle by altering the timing and spacing of births. Improved birth control technology, especially the pill, played an important part in these developments, and at the same time generated higher expectations about the control of fertility. The medical professions of some countries began to find the abortion issue increasingly problematic, while illegal abortion was known to be widespread. Women's movements raised the consciousness of women about their right to equality with men, including sexual freedom and the control of fertility. Finally, political climates were favourable to the liberalisation of law in areas of personal and sexual life. Laws were passed in several countries decriminalising suicide and homosexuality and abolishing capital punishment.

The need for abortion law reform was brought to popular attention by the case of Sherri Finkbine, an Arizona woman whose case was widely publicised in all four countries. Finkbine sought an abortion after having taken Thalidomide. Arizona law did not permit abortion on grounds of foetal abnormality, and when her abortion was refused she travelled to Sweden. A rubella epidemic in the same period had similar effect on women's consciousness about abortion.

In Britain the Abortion Law Reform Association mounted the campaign for liberalisation. This was a left leaning single issue group, not specifically feminist but led largely by elite women. It claimed support from a number of other elite organisations including the National Council of Women and the Family Planning Association, and in time attracted support from churches, Labour Women and a number of conservative and well known doctors. Its campaign cited public opinion in favour of change, medical confusion about existing law, and the widespread illegal sale of abortifacients. Abortion law reform was opposed, largely ineffectively, by the Catholic Church, and by the newly formed Society for the Protection of the Unborn Child. Major medical groups opposed radical change in the law but conceded the need for a degree of revision, concurring with the Church of England that abortion should remain a medical decision.

A 1967 reform bill was passed in the House of Commons as a Private Members Bill after the deletion of a 'social clause' providing for abortion where the woman's capacity as a mother might be overstrained. The Bill was amended in the House of Lords, the issue of how to define the degree of risk to the woman's health being resolved through a late suggestion that abortion should be legal if the risk to the life or the risk of injury to health was greater by continuing the pregnancy than by terminating it. Uncritically accepting arguments made by the opponents of reform, this definition effectively made abortion available in the normal circumstances of early pregnancy (Francome, 1984, ch. 4).

The *Abortion Act 1967* permitted abortion when in the opinion of two doctors it was necessary to protect the physical or mental health of the woman, with the health ground very broadly defined. The *Infant Life (Preservation) Act* had set 28 weeks as the point at which a foetus was assumed to be 'capable of being born alive', and this continued to mark the limit to legal abortion. In 1974, following a review by the Lane Committee,

the time limit was reduced to 24 weeks for abortion on extended grounds. This limit was retained in the 1990 *Human Fertilisation and Embryology Bill* (Murphy, 1991), but pressure has continued to reduce it to 20 weeks. In fact few abortions are performed later than this.

The *Abortion Act* does not apply in Northern Ireland, and medical practice there continues to rely on the Bourne judgement. A significant, but unknown, number of terminations take place in the region (Randall, 1992).

The British Act was quickly followed by reforms to broaden the acceptable medical grounds for abortion in both Australia and Canada. In Australia abortion is governed by the laws of the separate states. During the 1960s abortion law reform groups were established in all states, campaigning in association with civil liberties and progressive church organisations. Coleman (1988: 76) notes that abortion law reform predated the involvement of a rising women's movement.

In 1969 South Australia passed an act closely modelled on the British Act. Though reform had been foreshadowed by Labor, it was actually carried through by a Liberal-Country Party government sympathetic to civil liberties and 'social' issues and eager to avoid the police corruption rampant in other states around illegal abortion. The law allowed abortion when two doctors agreed that 'continuance of the pregnancy would involve greater risk to the life of the pregnant woman or greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated'. It set a maximum gestation period of 28 weeks and limited abortions to approved hospitals. The decision went beyond the guidelines of the Australian Medical Association at the time (Siedlecky and Wyndham, 1990: 79). In Victoria and New South Wales liberalisation came via judicial decision, in Victoria after a bitter campaign to expose police corruption and in New South Wales in a prosecution aimed at pre-empting the exposure of corruption (Coleman, 1988: 78-80). The Menhennitt ruling in Victoria (1969) and the Levine judgement (1971) in New South Wales were based on the Bourne case, and allowed broad interpretation of health grounds, the Levine ruling including the effects of social and economic stress. These rulings quickly gave wider access than under the South Australian legislation, effectively establishing abortion on request, mainly through freestanding clinics.

The only attempt to set a national standard for abortion law reform concerned introduction of reform legislation for the Australian Capital Territory by the Whitlam Labor government in 1972. The Australian Labor Party has strong Catholic roots, and abortion has been treated in the Parliament as a conscience issue. When the bill failed the government set up the Royal Commission on Human Relationships to enquire into a range of issues into personal and sexual life with abortion as a major focus. The Commission's 1977 recommendations for liberal abortion legislation and the establishment of free-standing clinics were dismissed by the conservative Liberal government by then in power. No state has since attempted legislative liberalisation of abortion law in Australia.

A similar liberalisation of abortion law was passed in Canada in 1969. The measure came as part of a wider reform package of the newly elected Liberal Trudeau government, which also included measures legalising contraception, divorce and homosexuality. Initial impetus came from elite legal and medical organisations seeking to clarify legal provisions in the light of contemporary practice. The move was supported by popular opinion following the Finkbine case and endorsed by a Parliamentary Standing Committee (Campbell and Pal, 1989: 172-9).. The Canadian legislation provided that an abortion would not be criminal if performed in an approved or accredited hospital and approved by a hospital 'therapeutic abortion committee' on the ground that continuation of the pregnancy would or would be likely to endanger the life or health of the woman. Hospital committee approval required the agreement of three doctors not including the doctor who was to perform the abortion.

In the United States, as in Australia, the medical regulation of abortion falls under the jurisdiction of the states. Attempts to clarify and liberalise state laws began in the early 1960s. In a detailed case study of abortion law reform in California, Luker (1984, ch. 4) argues that the impulse to reform came largely from small groups of elite professionals in public health and medicine, law and the legislature. California statutes dating from 1849 made the procuring of a miscarriage a criminal offense except where necessary to preserve the woman's life, with subsequent case law affirming the special status of physicians in making such a judgement. Medical practice had come to vary widely, with medical opinion increasingly divided between 'strict' and 'broad' constructionists of the law. Impetus from

individual legislators gained support from wider elite constituencies and medical bodies and the beginnings of a grass roots movement.

The 1967 California law permitted abortion in an accredited hospital, subject to determination by the hospital's therapeutic abortion board that the pregnancy would 'gravely impair' the physical or mental health of the woman. It also permitted abortions when the pregnancy was the product of rape or incest, or when the woman was the victim of statutory rape and below the age of 15. A clause permitting abortion on grounds of grave physical or mental defect was dropped to avoid veto by Governor Ronald Reagan. By 1973 abortion reform statutes had been passed in one third of all states.

Thus by the early 1970s all four countries had instituted legal provisions distinguishing 'therapeutic' from 'criminal' abortions. The effect of these reforms was to define therapeutic abortion as a legitimate form of medical treatment, subject to regulation by medical authorities and under hospital control. These reforms, many of which did little more than bring law in line with common practice, were outcomes of elite movements and typically included at least a degree of support from within the medical profession. In most cases reform preceded any significant participation by women's movement or other popular political organisations.

As a form of medical care, access to legal abortion depended on the attitudes of individual doctors and, in much of the United States and Canada, on the operation of hospital committees. Abortion became most freely available in Britain and Australia, where medical grounds were quickly extended to include 'social' reasons and amounted to abortion upon the request of the woman. The California law had a similar effect. By 1970 virtually all women applying for abortions were being granted them (Luker, 1984: 94). In all countries medical decisions varied widely by region, and by the class and race of the woman. In Canada and many US states the operation of hospital abortion committees varied significantly, with many Canadian hospitals declining even to establish committees.

In the United States and Canada, however, the successful move to liberalise medical regulation of abortion laws served also to trigger new movements among women for their repeal and the decriminalisation of abortion. These

movements claimed abortion as a woman's right, part of a wider set of rights to the control of her body and its reproductive functions.

In the United States, an activist women's movement began to challenge the strategy of reform even before the passage of the California law. Radical women's groups, many of them local, applied campaign strategies including consciousness raising, civil disobedience and demonstration projects, this last including the establishment of clinics in which abortions were provided by non-medical personnel (Luker, 1984, ch. 5; Petchesky, 1986: 125-32). National support came from the National Organization of Women and the National Association for Repeal of Abortion Law. By 1973 four States had passed repeal legislation, including a 1970 New York bill giving abortion on request in the first 24 weeks of pregnancy. The bill imposed no residency requirement (Francome: 1984: 104-5).

The movement toward repeal culminated in the decisions of the United States Supreme Court in the paired cases of *Roe v Wade* and *Doe v Bolton*, the first striking down an unreformed Texas statute prohibiting abortion and the second a Georgia reform statute. The two cases are commonly referred to together as *Roe v Wade*. The ground for the decision had been prepared by several other cases immediately preceding it. In the 1965 case *Griswold v Connecticut*, concerning the use of contraceptive measures, the Court had recognised the existence of a constitutional right of privacy within marriage. This decision was extended to single persons in 1972 when the Court ruled that the marital couple were not an entity but two individuals each of whom had rights to privacy.

The right to privacy was based on the Ninth and Fourteenth Amendments to the US Constitution. In the *Roe v Wade* decisions the Court held that the right to privacy in marital and sexual life was broad enough to encompass a woman's right to decide whether to terminate her pregnancy. This right was, however, by no means absolute, and the Court maintained that the decision did not entail an unlimited right to do with one's body as one pleases or abortion on demand. The right to privacy also attached to the doctor-patient relationship, precluding the intervention of the state in the abortion decision between a woman and her physician during the first three months of pregnancy. The Court affirmed the right of the physician to administer medical treatment according to his professional judgement, and

that the abortion decision in all its aspects is inherently and primarily a medical decision, basic responsibility for which lies with the physician.

The interests of the state were found to be divided between that of preserving and protecting the health of the pregnant woman and that of protecting the potentiality of human life. The decision held that these interests were separate and distinct, each becoming 'compelling' at a different stage of pregnancy. The Court resolved these competing interests through a developmental, trimester framework. State regulation of abortion was unconstitutional during the first trimester. During the second, the state might intervene to protect the woman's health. In the third, associated with foetal viability, the state's interest in potential life could justify prohibition of abortion except when necessary to preserve the life or health of the mother. The decision in the accompanying case *Doe v Bolton* invalidated statutory requirements that abortions be performed only in accredited hospitals with the approval of the hospital abortion committees, but limited the performance of abortion to licensed physicians (Francome, 1984: 122-7; Petchesky, 1986: 289-95; Rodman, Sarvis and Bonar, 1987: 102-3; Rubin, 1987, ch. 3).

The 'rights' conferred under the *Roe v Wade* decision are ambiguous. While the decision appears to entitle the pregnant woman to an abortion in the first trimester of pregnancy, such right is clearly mediated by the medical authority of the attending physician. The right is thus ambiguously a right of the woman to seek an abortion or a right of the doctor to practise medicine in accordance with his or her professional judgement. This right is further limited by the developing rights of the foetus, which become significant in the last trimester.

The Supreme Court decision invalidated virtually all state laws governing abortion, including legislation for both reform and repeal. The new situation it established endorsed the middle class medical model predicated upon a private, confidential doctor-patient relationship. At the same time it founded that relationship on a new presumption, that the woman was seeking a fundamental right related to her own health (Petchesky, 1986: 291-2). With access no longer fettered by hospital restrictions, the way was cleared for the establishment of freestanding abortion clinics.

In Canada also the liberalising reforms of 1969 served to stimulate further moves toward repeal and decriminalisation, working through an alliance

between women's groups and liberal doctors. The central figure in Canadian abortion politics has been Dr Henry Morgentaler, a Montreal doctor. In 1967, appearing before a parliamentary committee reviewing Canada's abortion laws, Morgentaler had declared that abortion ought to be seen 'not as a privilege but as a right' (Day and Persky, 1988: 4). When the 1969 reform law soon proved ineffective in making abortion available to Canadian women, mainly because of its cumbersome requirements that therapeutic abortions take place only in accredited hospitals and be approved by hospital committees,⁴ Morgentaler provided abortions from a Montreal clinic without the required accreditation and committee certification. He subsequently set up additional clinics in Winnipeg and Toronto. He was arrested for the first time in 1970 and repeatedly for more than a decade thereafter, serving a prison sentence in 1975.

The history of his jury acquittals and judicial convictions on appeal over nearly two decades is intertwined with Canadian constitutional development and the aspirations of the women's movement to secure constitutional support for women's right to equality. In 1975 the Supreme Court of Canada declined to recognise abortion as protected under the 1959 *Bill of Rights*. It faced the issue again when in 1986 Morgentaler and two others appealed convictions to the Supreme Court on the grounds that the 1969 abortion law was inconsistent with the Canadian *Charter of Rights and Freedoms*.

In 1988 the Court ruled the law unconstitutional because it violated a woman's right to 'life, liberty and the security of the person'. Three majority judgements agreed that in delaying abortion or making it practically unavailable the 1969 law was detrimental to the health of the woman, and that this was a violation of her security of person. Some judgements went further. One affirmed that the right to security of the person is a right to be free from interference by the state with one's body, and the other that a right of liberty is involved in the woman's choice whether to procure an abortion. In considering the competing interest of the state in the protection of the foetus, the judgements found the delays and

4 A number of Provincial governments failed to accredit hospitals, and many hospitals either were too small to provide a committee of the necessary size or declined to set up committees at all. Some committees issued no authorising certificates.

procedures employed disproportionately harmful and hence not reasonable limits to the rights of the woman in a free and democratic society (Day and Persky, 1988: 180-95; Mandel, 1989: 273-307; Campbell and Pal, 1989: 197-200).

The effect of the decision was to decriminalise abortion at the national level, leaving Canada without an abortion law. While the rulings stated that the existing law violated a woman's right to security of person, only one judge affirmed a positive right to abortion. Conservative government legislation approving abortion on broadly defined health grounds in early stages and more restrictive grounds in later stages foundered in a chaos of multiple amendments. While the federal government has since indicated it intends to legislate, two national women's organisations have opposed recriminalisation in any form.

In all four countries, though to varying extent, the liberalisation of abortion law and increasing visibility of the frequency of abortion has served to crystallise social and political opposition movements actively attempting to reverse the gains. The US Supreme Court decision in *Roe v Wade* brought a much stronger response than earlier reform legislation, and is widely credited with responsibility for the formation of the Right-to-Life Movement in the United States and elsewhere.

In Britain the Society for the Protection of the Unborn Child in 1966 and the more extreme Catholic LIFE in 1970 pursued both parliamentary and activist campaigns to tighten the abortion law (Francome, 1984: 158-82). A number of Private Member's bills to restrict grounds and reduce time limits have so far failed, but the maximum time period has been reduced to twenty weeks.

In Australia initial opposition came from Catholic and Lutheran groups (Francome, 1984: 149). The first Right to Life group was organised in 1970, and became active on a national level in the mid-1970s. This and other anti-abortion groups have continued to campaign for stricter laws governing abortion and for restrictions of other kinds, the campaign becoming extremely vocal in the 1980s. These groups are clearly associated with the American Right to Life organisation (Coleman, 1988: 89; Siedlecky and Wyndham, 1990: 97). A number of Private Member's bills have been introduced to state and federal legislatures without success.

Though an active anti-abortion campaigner holds the balance of power in the New South Wales upper house he has been unable to secure even a credible minority vote on bills to outlaw abortion.

In Canada anti-abortion opposition mounted in response to the repeated activism and prosecutions of Morgentaler, who was seen by groups opposed to abortion as deliberately breaking the law as well as taking human life. Opposition too has been spearheaded by constitutional challenges based first on the Bill of Rights and subsequently on the Charter of Rights and Freedoms. Catholic crusader Joe Borowski has mounted a series of cases maintaining that the foetus is a person and thus has rights protected by law. These cases have so far been unsuccessful, the Saskatchewan Supreme Court ruling in 1984 that there is no existing basis in law justifying the conclusion that foetuses are legal persons (Mason, 1990: 130). As of 1990 the appeal process had not yet been exhausted (Campbell and Pal, 1989: 177-8).

American opposition to abortion, having begun among Catholic professionals, quickly came to include newly mobilised mass participation by women with children, members of fundamentalist churches and moral conservatives (Luker, 1984, ch 6). The movement mobilised rapidly and began to apply many of the activist protest strategies of the civil rights and women's movements. State governments responded to the decision with legislation limiting and regulating abortion, some directly contradicting the Supreme Court decision. Court challenges have resulted in a series of decisions largely confirming *Roe v Wade*, but there has been a tendency to fetter the abortion decision with limitations. In July 1992 the Supreme Court ruled that states may impose a number of conditions on abortion, including a waiting period of 24 hours, notification of the parent of a minor, and conditions establishing informed consent including information about foetal development and alternatives to abortion including adoption. The decision ruled invalid the requirement that a woman notify her partner of her intention to abort (*Sydney Morning Herald*, 2.7.92). By a thin majority, however, the Court declined to overturn the constitutional basis of a right to abortion.

In summary, legislative and judicial developments over the last two decades have resulted in two bases for women to have access to legal abortions, as a 'medical entitlement' and as a 'body right'. In Britain and Australia

abortion has become largely accepted as a legitimate medical treatment in broadly defined circumstances, part of the woman's entitlement to medical care. Access is mediated by medical authority, requiring in some jurisdictions the concurring opinion of two or more doctors. Medically justified grounds include not only physical but also mental health, the latter often extended to acknowledge social factors affecting the well-being of the woman, her other children and the future circumstances of a foetus were it to be born. These grounds amount in many circumstances to abortion upon request, though it may matter a great deal to what medical authority the request is addressed.

In the two countries of North America abortion has been given judicial endorsement as forming part of the liberal rights of citizenship in liberal society, an expression of the woman's constitutional rights to individual freedom and personhood. The abortion decision is equally mediated by medical authority, the US right being ambiguously the right to privacy of the woman and the right to privacy of the medical consultation. In these countries the right to abortion is further mediated by the division of power between Federal and lower level governments, with State and Provincial governments imposing limitations on the process of abortion decision, some of them in defiance of the Federal judiciary.

Abortion has been much more highly politicised in the countries of body right than in those of medical entitlement, where it has been sheltered by the claim of medical authorities to professional autonomy. The liberal politics of body right have exposed abortion to counter mobilisation by coalitions of conservative forces responding to deeply rooted social change, most visibly in women's roles and family life. Much of the opposition has come from women defending the value of traditional family life (Luker, 1984; Ginsburg, 1989). The abortion issue is believed, for example, to be responsible for the failure of the Equal Rights Amendment to the American Constitution (Luker, 1984: 205; Petchesky, 1986: 271).

The liberal ground of body right structures politics in the individualist terms of liberal ideology, and that ground has proved more vulnerable than medical entitlement to a politics asserting the rights of others. There is a clear pattern in which those countries giving body rights to women also give more recognition to competing rights of others. The rights of medical personnel are similar in all countries and not discussed here. There is little

difference in the rights accorded to the husband or male partner of the women, but more substantial differences are to be found in the implicit acknowledgement of foetal rights and the relative rights of a pregnant minor and her parents.

The rights of a husband or male sexual partner to a role in the abortion decision have been asserted in a number of countries but to date have not been accepted in any. They were denied in English cases in 1979 and 1987 (Mason, 1990: 115-16), and most recently in the July 1992 decision of the United States Supreme Court. Greatest recognition has been given in Canada where under the 1969 law two thirds of hospital abortion committees required consent of husband, some committees also requiring the consent of the male responsible for the pregnancy of a single woman. In 1981 the Ontario Supreme Court ruled that fetuses and natural fathers had rights, drawing upon the 'birth for benefit' provision of Scottish law giving rights of inheritance to a foetus subsequently born alive (Mason, 1990: 130). This decision was subsequently overturned, and the consent requirements of hospital abortion committees invalidated in the judgement of the Supreme Court of Canada in 1988.

In no country has the foetus been given legal recognition as a person, though such cases have been brought before the courts repeatedly in all countries. There is, however, an implicit right of the foetus expressed in the limitation of the abortion of a potentially viable foetus to circumstances in which the woman's life or physical health is jeopardised. Thus British law limits abortion on lesser grounds to the first 20 weeks of pregnancy. Tacit recognition of the potential rights of the foetus is most formalised in the trimester framework of *Roe v Wade*, which gives the state an explicit interest in the life of the foetus in the third trimester. Similarly, majority opinion in *Morgentaler* held that the law had a valid purpose in the protection of foetal life. In the United States the right to life of the viable foetus has been strengthened by a 1989 Supreme Court Decision in *Webster v Reproductive Health Services* permitting states to require a test for viability of any foetus believed to be 20 or more weeks in gestation.

The vulnerability of body rights to the competing claims of others is clearest in the conflict between the rights of a pregnant minor and the rights of her parents. In Britain and Australia the right of a minor to abortion is treated in the more general context of consent to medical treatment and is defined as a

matter of medical discretion. The Gillick case in Britain provides the precedent in both countries. This case concerned the right of public authorities to give contraceptive advice to a minor without the consent of the parent, and resulted in a ruling in the House of Lords that the doctor might do so where the minor was able to understand the nature and consequences of the procedure and after having attempted to persuade her to involve her parents (Mason, 1990: 50-2). In contrast, the issue continues to be heavily politicised in the United States. *Roe v Wade* having left the issue undecided, a 1976 Supreme Court decision invalidated blanket provisions requiring parental consent to the abortion of a 'mature minor'. In 1979 it began to develop the position, elaborated in subsequent judgements, that States may require that parents be notified or consulted providing the minor has the freedom to seek approval by a court before such notification. The court may determine either that she is sufficiently mature and well informed to make her own decision or that an abortion would be in her best interests. The court has since continued to elaborate this principle. Its July 1992 decision permitted States to require parental notification, though it continues to require an alternative route through the courts.

5 Social Rights to Abortion

Whether legalised as medical entitlement or body right, access to medically legitimate abortion has caused markets in illegal services to largely disappear in all four countries (Francome, 1988: 463; Siedlecky, 1988: 25; Tietze et al., 1988: 482; Sachdev, 1988: 72). At the same time, the numbers of abortions being performed have increased significantly since the 1960s. It has been estimated that in the early years after legalisation in the United States some two thirds of legal abortions replaced formally illegal procedures (Jaffe et al., 1981: 13-14). After steep rises in the first decade after legalisation rates in Britain, Australia and the United States appear to have been stable since the early 1980s.

Abortion rates, shown in Table 1, differ strikingly in the countries under consideration. Abortion is almost twice as frequent in the United States as in the other three countries. Rates are almost twice as high among black and minority women.

Table 1: Abortion Rates in Four Liberal Welfare States

Country	Rate ^(a)	Year
Australia	16.6	1988
Canada ^(b)	10.2	1987
England and Wales	14.2	1987
United States	28.0	1985

Notes: (a) Rate is number of abortions per 1000 women aged 15-44 years.

(b) The figure for Canada does not include abortions performed outside hospitals in clinics or doctor's surgeries, and also excludes abortions received in the United States. Sachdev (1988) estimates that these increase the rate to 11.2. Reflecting the situation before the 1988 decision in *Morgentaler*, even this corrected figure does not necessarily represent the present situation in Canada.

Source: Henshaw, 1990: 85.

Medically regulated in all four countries, the provision of abortion services has tended to be shaped by the contours of the health care system into which it has been absorbed. Thus the effective availability of abortion services depends on the way in which health care is organised and the role of the welfare state in supporting the facilities and expertise required. The important dimensions for the social distribution of access to abortion are the scope and form of public provision and the division of health care into public and market sectors, the working of the system in giving access to abortion within the permitted time period, and the role of medical regulation in the operation of hospitals and free-standing abortion clinics. Together these determine the availability of a 'social right' to a minimum standard of access to abortion services.

Taylor-Gooby (1991: 96) notes that elements of social democratic universalism make Britain anomalous in the group of liberal welfare states. In actuality the category of liberal welfare state has little meaning for the discussion of health services. The health care systems of virtually all liberal welfare states contain such social democratic elements, with universalist principles underlying those of three of the four considered here. Only in the

United States is the social right to medical care based on classically liberal selectivist, class-divided arrangements.

Universalism in health care provision takes two forms, the direct provision of health services by public authorities, as in the British National Health Service, and indirect support through universal compulsory insurance, as in Canada and Australia. Both forms make health care available to all citizens at little or no direct cost, but they differ in their relation to markets for medical services. While direct provision replaces the private market with public services, the insurance model delivers public support through the private market.

The first wave of medical legitimization of abortion largely limited the operation to hospitals and the hospital framework of medical authority. Campaigns to widen access to abortion have in a number of countries included challenges to this limitation, including the establishment of freestanding clinics for first trimester abortions. Set up by private philanthropic and commercial bodies responding to women's need for abortion, these clinics provide low-cost services and are organised to facilitate processes of medical authorisation. In the US women's health movements also challenged medical control, with abortion services being performed by women without qualifications as a physician (Zimmerman, 1987: 456). While freestanding abortion clinics have become established parts of the health care system in many jurisdictions, abortion remains under medical control in all four countries. In the increasingly restrictive US environment a women's health movement has again begun to promote abortion and menstrual extraction on a self-help basis (*New York Times*, 10 March 1989).

In North America and Australia the politicisation of abortion has evoked bitter and sustained opposition to the public funding of abortion services. These moves have been most effective in North America, where the constitutional politics of body right has been accompanied by active political intervention in social rights to abortion services.

In general the legal legitimization of abortion has served to place it within pre-existing frameworks of health provision. In Britain the extension of therapeutic abortion under the 1967 Abortion Act was directly assimilated into the hospital services of the pre-existing National Health Service (NHS).

Effective access to NHS abortion services depends both on the working of the NHS system in general, including its patterns of appointment and waiting lists, and on resistance by medical authority specific to abortion.

A woman seeking an abortion under the NHS must attend the general practitioner with whom she is registered and request referral to a specialist gynaecologist. If her termination is approved it will be performed in hospital without cost to her. The most significant factor affecting the availability of an NHS abortion is the attitude of senior gynaecologists, and there is marked variability from region to region on this account. There are, however, also repeated and lengthy delays which, when compounded by the uncertainty of medical approval, result in many women seeking abortions outside the NHS. Because of these factors less than 50 per cent of terminations are provided through the public health system. Abortion is thus an exception to the general pattern of NHS services in England and Wales, in which well over 90 per cent of care is provided by the NHS. This proportion was stable over a decade from the early 1970s to the early 1980s (Paintin, 1985: 7-9).

Commercial and non-profit services provide the remainder of terminations in about equal proportions, mainly from fee-charging abortion clinics. These clinics advertise, accept self-referred patients, and provide services within two to five days at relatively low cost. A first trimester abortion in a private clinic currently costs about £400 (Preterm Foundation, personal communication). Some clinics reduce fees for women unable to pay the full charge.

In Australia abortion was quickly accommodated within the established system of health care funding, but that system itself has been the subject of political contention and has been repeatedly restructured in period since the early 1970s. Universal compulsory health insurance was reinstated in 1983, and provides general practitioner and public hospital treatment at little or no cost to the patient. The insurance base of the health system permits the patient free choice of doctor and is easily extended to include doctors in either hospital or clinic practice. A clinic abortion in the first trimester currently costs about A\$120 to the patient after collection of the insurance rebate (Preterm Foundation, personal communication). As numbers of abortions have risen many hospitals have imposed quotas on the numbers

performed, and the share of abortions undertaken in freestanding clinics has increased (Siedlecky, 1988: 26).

Opposition to abortion in Australia has more frequently been directed to legal restriction than to the denial of public funding. A 1979 move to remove abortion from the schedule of insurance benefits was defeated, as was another in 1989 (Siedlecky and Wyndham, 1990).

The American health system is a patchwork of arrangements applying to different social groups. The largest part of the population is covered by private insurance, usually provided as a fringe benefit of employment. By 1983 some 63 per cent of the population had private insurance (Gilbert and Gilbert, 1989: 124-5). Most private insurers cover abortion, but it is common for this to be a part of maternity coverage, which is often an expensive optional supplement and is not always offered to unmarried employees and dependants (Jaffe, Lindheim and Lee, 1981: 52). Separate programs provide for veterans and federal government employees.

A means-tested public insurance program, Medicaid, covers a further ten per cent of the population having very low incomes. Medicaid is a joint Federal-State program in which States must meet federal requirements to qualify for federal funds. Entitlements vary significantly from State to State. Some 15 per cent of Americans have partial or no insurance cover from either public or private sources. Some of these are low-income workers who do not qualify for Medicaid, while others live in areas where Medicaid benefits are unavailable (Gilbert and Gilbert, 1989: 126).

In the period following *Roe v Wade* the provision of social rights to abortion has been rapidly and heavily politicised. The decision evoked campaigns through both legislatures and courts to place limits on the public funding of abortion services. A 1977 Supreme Court decision in *Beal v Doe* ruled that a state might restrict funding under the Medicaid program to medically necessary abortions. In the same year Congress passed the *Hyde Amendment* precluding the use of Medicaid funds for any abortion except where the life of the mother would be endangered, and the Supreme Court subsequently upheld the restriction.

In *Roe v Wade* the Supreme Court had not found grounds for a right to abortion in the equal protection provisions of the American Constitution. In

a 1977 case *Roe v Maher*, companion case to *Beal v Doe*, the Court focused again on the constitutional question of the right to abortion. It held that because a woman could turn to a private source of support without state interference, a state's policy to deny Medicaid support for elective abortions did not infringe her fundamental right to privacy (Rodman et al., 1987: 115-16). In the language of rights, the Court divorced a civil right to abortion from a social right, holding that the Constitution did not confer a social right to a minimum standard of access.

In the first years after the decision some 25 per cent of all legal abortions had been funded through Medicaid. By 1978 the number of abortions funded through Medicaid had been reduced to one per cent of the previous figure (Rodman et al., 1987: 115-16). Some states have nevertheless continued to provide abortion funding, and these states account for by far the largest number of Medicaid-eligible women (Tietze et al., 1988: 476). It was estimated that in 1978 some 84,000 women denied Medicaid-funded abortions obtained them in the private sector, a maximum of 3,000 obtained illegal abortions, and some 14,000 gave birth (Cates, 1981, cited in Tietze et al., 1988). Many states have also established procedural requirements, and these too have been the subject of court rulings. Requirements that abortions be performed only in approved hospitals have largely been disallowed.

The Reagan and Bush periods have seen further initiatives to restrict abortion enacted with the support and encouragement of the White House. These measures extended constraints on abortion beyond Medicaid, applying to any form of federal financial support. Department of Health and Human Services regulations prohibit doctors and counsellors in federally funded family planning clinics from discussing abortion with women. Food and Drug Administration regulations preclude the inclusion of information about abortion in information accompanying oral contraceptives. Most significant, however, is the decision of the US Supreme Court in *Webster v Reproductive Health Services*. The case upheld a Missouri statute prohibiting the use of public employees or facilities for performing abortions not necessary to save the mother's life. The statute also prohibits the use of public funds, employees or facilities for the purpose of encouraging or counselling for an abortion unless necessary to save the mother's life. The definition of public funds or facilities is extremely broad,

covering all public employees and private facilities receiving indirect public support, such as private hospitals on public land or using public water (Eisenstein, 1991: 105-7).

In the United States some 80 per cent of abortions are now provided in freestanding private clinics or doctor's surgeries, with large providers accounting for most services (Tietze, Forrest and Henshaw, 1988). In 1990 a first trimester abortion cost as little as \$200, with prices subject to wide variation (National Abortion Federation, 1990). Major medical funds cover abortion providing the woman or her husband has sufficiently comprehensive insurance. There are few services outside metropolitan areas, some 83 per cent of US counties having no abortion provider (Anderson, 1991). The politicisation of abortion has led many rural doctors to stop providing the service (Ginsburg, 1989: 55; *Sunday Times Union*, Albany NY, August 26, 1990).

Canadian health care is funded through universal compulsory insurance, nationally based but administered by provincial governments. The system provides free in-patient and out-patient care, with funded physician services subject to a degree of cost sharing in some Provinces. Most doctors bill the medical fund directly. There is, however, significant variation in the availability of services from province to province. Established before the 1969 reform legislation, the health system absorbed the funding of abortion services where these had been approved by the relevant hospital therapeutic abortion committee.

The 1988 decision overturning that legislation evoked strong reactions from provincial governments. While Ontario and Quebec moved to pay for all abortions whether performed in hospitals or clinics, all other provinces announced measures to limit abortions to hospitals or to withdraw public funding (Mandel, 1989: 292; Day and Persky, 1988: 20-1). The strongest reaction came from British Columbia, where the provincial government instituted regulations to the Medical Services Act withholding funding from abortions except where the woman's life was in danger. The measure was quickly overturned by the Supreme Court of British Columbia. Other provinces have nevertheless continued to introduce restrictions including limitations on funding. Provincial responses to *Morgentaler* have tended to follow the contours of Canada's political economy, urban industrial provinces including Catholic Quebec maintaining support for abortion while

primary producer areas have withdrawn support. These variations are compounded by significant variations in the inter-provincial distribution of medical resources (Mandel, 1989: 295).

Before the *Morgentaler* decision freestanding abortion clinics were legal only in Quebec, but Morgentaler and his associates had also established clinics in Toronto and Winnipeg which were legalised in the decision. In 1990 a first trimester abortion in one of these clinics cost about C\$250.00 (National Abortion Federation, 1990).

6 Abortion, Decommodification and Social Stratification

Abortion is now readily available in all four countries, as a medical entitlement in Britain and Australia and as a body right in the United States and Canada. The pattern of civil and social rights presents the conventional view of the welfare state with a paradox, for it associates the strongest civil rights with the weakest development of social rights. I suggest that this is an outcome of the identification of abortion with liberal ideology in the North American cases.

In comparison with the other liberal welfare states, the United States accords women both the greatest rights and the least. However much eroded since the Supreme Court decision of 1973, *Roe v Wade* gave women, in consultation with medical practitioners, the right to choose whether or not to proceed with a pregnancy. The Canadian decision in *Morgentaler* will in all likelihood prove to have a similar effect. While women in these countries must negotiate their decision through medical channels, they begin the discussion with a presumption that the right of choice is their own. In this sense, the body right of North American women is stronger than the medical entitlement of their sisters in Britain and Australia. In these countries of medical entitlement women must argue their needs in the indirect language of health, without any presumption of right.

At the same time, however, body right to abortion has been more vulnerable than medical entitlement to political erosion, and is probably also more unstable. The claim to body right casts abortion in the terms of the ideology of possessive individualism, and in doing so evokes the broader terms of

that ideology. Key among these terms are individualism and the market, while not included is social equality.

These links are clearly visible in the development of abortion policy in the United States. The concession of woman's body right in *Roe v Wade* was quickly followed by political mobilisation against it in the streets, in the Congress, and in the courts. These forces have been directed at reversing the right to abortion, and the judicial reversal of *Roe v Wade* remains their primary goal. But the forces opposing abortion have meanwhile sought to reduce the numbers of terminations taking place, and in the process have politicised the machinery of the welfare state. The breadth of this politicisation is extensive, including not only hospital and medical authorities but virtually every government instrumentality including those governing drug approval and foreign aid.

The liberal terrain of body right has proved more vulnerable than that of medical entitlement to the limitation of woman's right by the potential rights of certain others, primarily the foetus and the parents of the pregnant minor. The competing rights of both receive more recognition in American law and practice than under the medical regimes of Britain and Australia.

The denial of a social right to a minimum standard of equality in access to abortion also follows the lines of classic liberalism. Identifying freedom with the market rather than the state, the ideology of possessive individualism divorces the issue of right in law from that of effective right in actuality. Implicit in this divorce is protection of the competing right of a further unnamed other, the taxpayer, whose moral commitments may preclude sharing in the support of abortion through the collective auspices of the welfare state. While anti-abortion forces have attempted similar initiatives in the countries of medical entitlement, they have been largely ineffective in the face of the claims of medical authorities to professional autonomy.

Legal abortion is not now an expensive service. Nor is market price necessarily a deterrent, as the history of illegal abortion has long made clear. The high rates of abortion in the United States suggest that for most metropolitan women market provision is not a significant barrier.

At the same time, American provision through the market reproduces social stratification in abortion services. Access to insurance funding reproduces the occupational stratification of benefits attached to employment. Poor women in those States denying Medicaid support have to fund private services from scarce resources, and not all are able to do so. The far-reaching restriction of federally funded services under *Webster v Reproductive Health Services* in 1989 is expected to extend these effects to some middle class women. For women outside metropolitan centres the cost of abortion is increased by the cost of locating a service and of travel and accommodation. Though few now cross State boundaries in pursuit of an abortion, many travel considerable distances within their State of residence (Tietze et al., 1988: 477). In combination with legal restrictions, market provision also puts abortion out of reach of many teen-age women unsupported by their parents. Given their high abortion rates, these effects are felt especially strongly by black and minority women.

Canadian women have both body right and a social right supported by universal health insurance, but the establishment of body right in *Morgentaler* is beginning to evoke an anti-abortion backlash against social rights to abortion services. A pattern of unequal access to abortion appears to be emerging in which the political economy of inter-Provincial differences is reproduced in access to abortion. This pattern is compounded by the limitation of freestanding clinics to metropolitan centres in the industrial Provinces.

In Britain and Australia medical entitlement presumes social right, but differences between direct provision through the NHS and indirect support through universal insurance result in different outcomes for the woman seeking abortion. In Britain, delays, regional variations and the limitation of NHS support to hospital services has resulted in the emergence of a large private market for commercial and non-profit providers. Market abortions are more expensive in Britain than in any of the other three countries, leaving scope for stratification by race and income to be reproduced in access to private abortion services. Working through the market, Australian insurance funding covers clinic as well as hospital services. The Australian health care system provides the greatest equality of access of all four countries, but differences remain in the access of women in different States.

7 Conclusion

In the case of the liberal welfare state, the development of abortion services has taken two divergent paths. In Britain and Australia, the countries of medical entitlement, elite movements for abortion law reform have resulted in its legalisation as a form of medical care. In the result, the civil right to decide whether a woman will abort her pregnancy lies not with the woman but with the doctor(s) and the medical system. Women's access and the social right to a minimum standard of abortion services depends on the character of the health care system and its integration with the private market in medical services. The health care systems of both these countries have significant elements of social democratic universalism, and in principle these systems confer an equality of social right. In actuality, however, direct provision through the British NHS has provided less effective access than the insurance supported market system of Australia.

Women's movements have claimed that the right to abortion is about woman's individual personhood in liberal society and her right to personal autonomy in decisions concerning her body and fertility. Such a claim has been recognised in its fullest form in the liberal welfare states of North America, where such a body right has been recognised on the central terrain of liberalism in the ideology of possessive individualism. In the result, the right to abortion has been given expression in liberal terms, as a freedom to be exercised primarily through the medical market. On the same ground, a social right to an equal minimum standard of access has been denied. Abortion is largely a market service in the United States, the market providing services at competitive prices but through a limited number of large providers concentrated overwhelmingly in metropolitan centres.

Taylor-Gooby (1991) suggests that in the liberal welfare state gender conflicts tend to be waged through the legal rather than the welfare system, and that these conflicts become subsumed into the class conflicts of the market. This aptly describes the United States, where the liberal state is not contradicted by social democratic universalism in the health care system. Neither is such universalism in and of itself sufficient to guarantee a social right to abortion. A dual system of free public and expensive private services has emerged in Britain, and social rights are being withdrawn in some Canadian provinces. As access to low cost abortion in the early stages of pregnancy depends most directly on the use of the services of

freestanding abortion clinics, it is women who must travel who are most disadvantaged in all countries.

Whether as medical entitlement or body right, the outcome of the establishment of a civil right to abortion is much the same, for legal abortion is available in much the same degree in all countries. Medical entitlement has, however, proved more stable than body right in the face of mobilisation against women's access to abortion. Body right is vulnerable to the internal contradictions of liberalism in a way that medical entitlement is not, for it pits woman's claim to autonomy as an individual against the potentially equal rights of an increasing range of others. It is significant in this regard, however, that in no country has the right of a husband or male sexual partner been recognised.

More overtly politicised than medical entitlement, body right is also vulnerable to the competing rights of the generalised other in the taxpayer, pitting the civil right of all women against the social rights of the most disadvantaged. Where the liberal body right to abortion has been established, the social right to effective access has been weakened.

This conflict only restates the central contradiction of the liberal welfare state, between the freedom of the possessive individual in the market and the need of the person unable to command market resources. Abortion, however, states this contradiction in the distinctive terms of woman's claim to full and equal status as a possessive individual. In other instances civil rights have facilitated the support of social rights, mobilising political forces against possessive individualism in the development of the welfare state. In this instance the claim to a right to abortion on the high liberal ground of body right has constituted opposing forces in the same liberal terms, not supporting but rather undermining the welfare state.

Abortion does not fit at all neatly into the frameworks of established welfare state types. Civil rights to abortion services in the first trimester of pregnancy have become established across a much wider range of countries than the 'liberal' group discussed here (Glendon, 1987). Moreover such social rights as underpin effective access to abortion services depend quite directly on the character of the health care system in each country, and neither do these sit comfortably with the welfare state typologies generated in the study of economic policy and income support arrangements. What, then, can the comparison of civil and social rights to abortion services in a

group of 'liberal' nations have to say about the meaning of the 'liberal' variety of welfare state?⁵

The liberal type identified by scholars such as Titmuss (1974) and Esping-Andersen (1990) is predicated upon a commitment to the ideology of possessive individualism and the market (Macpherson, 1962) as the preferred means of meeting social needs. The present comparison of abortion rights and services considers the possibility that this ideology may be carried beyond fields of need in which the politics of class and income are salient, shaping access to abortion services in its image.

In language at least, not even the most liberal of the abortion regimes described here confers a body right in the literal sense of a right to the unrestricted freedom of the individual in the ownership of bodily capacities. Even the US Supreme Court decision in *Roe v Wade* specifically disclaimed conferring such a right. A clear notion of unfettered individual right has, nevertheless, become the unspoken assumption of subsequent decisions of the Court (Glendon, 1987: 24), and it underlies also the decision of the Supreme Court of Canada in *Morgentaler*.

These are not the only countries in which a woman may choose abortion as a matter of individual decision. In a review of abortion law in twenty countries of North America and Western Europe, Glendon (1987) lists five others as permitting elective abortion in early pregnancy.⁶ What distinguishes these from the US and Canada is the support of more genuine abortion choice through the provision of significantly more comprehensive support in pregnancy and child care in the types of welfare state found in continental Europe and Scandinavia.

The ideology of possessive individualism does not infuse medical entitlement to abortion in the UK or Australia to the same degree. There are, nevertheless, differences between these countries and others whose welfare states take different forms. Glendon (1987: 15-22; 33-9) notes differences between the Anglo-American common law and the civil law traditions among countries permitting 'abortion for cause' on the 'soft'

5 I am indebted to Ellen Immergut for raising this question.

6 These are Austria, Denmark, Greece, Norway and Sweden.

grounds of exceptional hardship for the pregnant woman.⁷ She argues that France and Germany have evolved forms of regulation which place the needs and interests of the pregnant woman in a context rooted in communitarian rather than individualistic values. In comparison with *Roe v Wade*, 'The West German decision emphasises the connections among the woman, developing life, and the larger community' (Glendon, 1987: 35).

Nor are the universalist elements of health care systems of otherwise liberal welfare states necessarily inconsistent with the market principle. The United States is exceptional in its lack of public provision, and that country has developed the largest private market. Glendon (1987: 20) comments that 'Only in America has a vast profit-making industry grown up around abortion'. The health insurance systems established in two of the other three countries work to underpin rather than to replace private markets for medical services. In Australia and, though unevenly, also in Canada most abortions are provided through clinics operating on a fee for service basis. In Britain abortion is exceptional among medical services in being provided as often through private auspices as through the National Health Service.

If the distinguishing features of the liberal welfare state are taken to be an ideology of possessive individualism and a structural privileging of market principles, then abortion services appear to have same broad character in at least some degree. Civil and social rights to abortion in these countries have been generated in a distinctive political environment giving direct representation to gender, religion and professional interest. The form these rights have taken, however, also appears to have been shaped by the ideologies and institutional forms of the broader social policy context.

7 These are England, Finland, France, West Germany, Iceland, Italy, Luxembourg and the Netherlands.

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