ABSTRACT

Title of Dissertation: SOCIAL POLICY AND SOCIAL SERVICES IN WOMEN'S PREGNANCY DECISION-MAKING: POLITICAL AND PROGRAMMATIC IMPLICATIONS

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This dissertation empirically evaluates the argument that welfare state expansion will reduce abortion. Its central question concerns the extent to which women's economic needs and the degree to which social services meet them influence their abortion decisions. It also investigates the characteristics and political behavior of pro-life, pro-social welfare Americans, the most likely targets of any effort to reframe welfare as a pro-life issue. To these ends, this project employs individual-level data from the National Election Study, the Fragile Families Study, and a survey of clients at Baltimore abortion providers and pregnancy centers. Other main data sources include state welfare policies and abortion rates, and neighborhood-level Census data linked to directories of child care and abortion providers. This project represents perhaps the first rigorous, social-scientific investigation of the link between economic assistance and abortion decisions. Its findings

contribute to the literature on policy compliance and policy tools, and carry implications for social welfare politics and the composition of party coalitions.

In many ways, data analyzed in this study align with the status quo of abortion and welfare policy and politics. Political debates over welfare are largely independent of political debates over abortion. Likewise, the cases in which the root issues associated with low-income women's abortion decisions could be exclusively solved by welfare policy are rare. Welfare policy appears to be an effective capacity-building tool with respect to abortion decisions for some women, in some ways, and in combination with other supports. The pro-life movement's current dominant approach to abortion policy appears to meet the movement's goal of reducing abortions more efficiently than a capacity-building approach. Investment in capacity-building policy or in political messages of that tone holds promise for progress toward their respective policy and political goals. On the other hand, expected gain is modest considering both of these efforts would stretch the limits of the possible in American politics.

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Dedication

This project is dedicated to the women whose participation made it possible, to the countless others in their shoes, and to those that serve them.

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A number of people played key roles in helping me start and finish this project, and I wish to thank them here.

Countless friends and colleagues stirred up the ideas and questions underlying this dissertation, especially during my time at Notre Dame and the Maryland School of Public Affairs, through conversations, class discussions, volunteer and internship experiences, and work for student organizations.

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The last four years in the Government and Politics doctoral program have been challenging yet rewarding ones, and I am thankful for the contributions of my dissertation committee and others in the department during this time. Mark Graber and Linda Williams provided valuable early guidance, helping me plan my course of study and craft research questions. Later in the game, Geoff Layman and Karen Kaufmann took me under their wings, patiently helping me improve upon many of the naïve shortcomings in my drafts as well as offering ideas for my next few years of work that I wish I could have

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Many others made it possible for me to gather and use the data in this study. First and foremost I thank all the anonymous women who participated in my survey and other studies. I also owe tremendous gratitude to the staff and leadership of the offices where my study was fielded—I am grateful for their willingness to give me access to their clients, for their suggestions for improving the survey instrument and its readability, and for their efforts in giving out and collecting the questionnaires. The Fragile Families Study was funded by a grant from NICHD (#R01HD36916) and a consortium of private foundations. Persons interested in obtaining Fragile Families contract data should see

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Chapter 1: Welfare Policy and Abortion Decisions: Theory and Some Evidence

1.1 Why Study Welfare's Impact on Abortion

1.1.1 The Political Context

These are uncertain times for the American social safety net. Debate over the welfare state intensified during the 1980s and 1990s, culminating in a 1996 reform bill that ended cash welfare as a federal entitlement, tightened work requirements and other conditions for welfare eligibility, and placed a time limit on welfare receipt (Lieberman and Shaw 2000; Soss et al. 2001). While other aspects of the welfare state have not eroded at the same pace, lawmakers are pondering downsizing or privatizing even such popular programs as Social Security and Medicare (Hacker 2002; Hacker 2004; Weir 1998). Mounting budget deficits (Hacker and Pierson 2005), polarized parties that play to the middle class (Weir 1998), and public antipathy toward "welfare" (Gilens 1999) combine with more stable factors such as low-income Americans' relative lack of political influence (APSA Task Force on Inequality and American Democracy 2004) to dim prospects for strengthening those public assistance programs aimed at the economically disadvantaged.

Yet not every proposal to tighten welfare programs for the poor made it into the 1996 reform. The introduction of a cross-cutting issue, abortion, reframed the debate over one specific proposal and played a key role in its defeat. This small victory suggests a potentially fruitful new approach to some aspects of welfare politics, and sets off the

prior empirical inquiry with which this dissertation is more immediately concerned—the connection between welfare programs and the abortion decisions of low-income women.

Abortion surfaced most clearly in the debate over a reform proposal called the "family cap," because it "capped" the number of children the government would support at the number a family had when applying for welfare. This would end the previous practice of increasing families' grants when new children were born, and was strongly supported by conservatives as discouraging out-of-wedlock childbearing and welfare dependency. The debate complicated when the National Right to Life Committee, the Catholic Church, and others argued that the denial of assistance could force more poor women to have abortions (Joffe 1998). This split in the Republicans' moral issues base effectively defeated the proposal, as the final bill left the matter to the states.

This debate elucidated tension in a fiscally and morally conservative GOP platform. It has not gone unnoticed by other scholars and commentators (Mirkin and Okun 1994; Pollitt 1999; Schroedel 2000). Since political elites of all stripes claim to want to reduce abortion (Clinton 2005; Feminists For Life of America 2001; Sanbonmatsu 2004), assistance programs figure prominently in calls for "common ground" in abortion politics (Dionne 2005; Dran and Bowers 1993; Mathewes-Green 1995; Mirkin and Okun 1994; Tribe 1990). Two widely-circulated op-eds of the 2004 presidential campaign went so far as to suggest that a vote for a fiscally liberal administration was the truly "pro-life" vote (Roche 2004; Stassen 2004). The rationale behind these arguments is that the expansive social and economic policies promoted by liberals would better protect families from economic hardship and would defray the material and opportunity costs of childbearing, making abortion less necessary.

1.1.2. This Study's Contributions

This dissertation puts the latter argument to an empirical test. Are women's economic needs and the degree to which these are met by social services decisive factors in their decisions between abortion and childbirth? Put another way, does more generous social welfare policy reduce abortion? While research in population studies, psychology, and health shows that economic hardship is a major reason behind many women's abortion decisions (Faria, Barrett, and Goodman 1985; Finer et al. 2005; Freeman 1978; Glander et al. 1998; McIntyre, Anderson, and McDonald 2001; Torres and Forrest 1988), much less is known about how social welfare policy might affect abortion usage. The question is newer still to political scientists, despite their calls for more study of how public policy affects abortion rates (Goggin 1993b).

A finding that social welfare generosity is associated with lower levels of abortion could have important implications for the future of the safety net and for American electoral politics. Such a finding would be a positive contribution to the literature on the behavioral effects of welfare policy, one that has largely emphasized politically negative effects such as long-term dependence, disincentives to work and marriage (Mead 1992; Murray 1984), encouragement of nonmarital childbearing (Moffitt 1997), and the migration of welfare recipients to states with the highest benefits (Bailey 2005; Peterson and Rom 1989). Politically, at issue is the coherence of the Republican coalition and its position on social welfare, given the party's official stance on abortion. Some political analysis surrounding the 2004 election suggested that Democrats could reclaim their former electoral advantage among the mass public by marginally softening their opposition to abortion restrictions or instead by communicating a desire to reduce

abortion through potentially effective alternative means, such as the expansion of social welfare assistance (e.g., Kirkpatrick 2004; Wallis 2004).

Secondarily, then, regardless of its findings with respect to the question of whether welfare generosity actually does have a "pro-life" impact, this dissertation begins to assess whether a mass constituency exists that might respond favorably to messages framing welfare as a pro-life issue. I identify those Americans who in 2004 continued to buck trends in partisan polarization by holding pro-social welfare, anti-abortion views. By examining their demographic group memberships and several aspects of their political behavior, I consider the extent to which the Democratic party—and by association, the welfare state—could profit from directing new messages at this group.

In summary, this dissertation makes two sets of contributions. By addressing the degree to which reproductive choices are constrained or influenced by women's economic circumstances, public policy, and the assistance that government and others do or do not provide, it subjects a largely untested hypothesis to empirical analysis and thus fills a gap in the literature on abortion demand and abortion decision-making. This study also contributes to another multidisciplinary literature on the behavioral consequences of welfare policy, this time considering a potential *positive* externality.

The second set of contributions, based in literature on the effectiveness of policy tools and in the political and other factors that govern selection of a policy tool, is of broad theoretical interest to political scientists. Here, I consider to what extent abortion and social welfare policies and the definition of these issues reflect the reality of their target populations, rather than politics. This research will also make suggestions about the comparative effectiveness of policy tools favored by political elites for reducing abortion

demand and supporting needy families. These two sets of alternatives are economic assistance versus restrictions on abortion access, and public versus private provision of assistance. This will allow me to comment on the coherence and practical effectiveness of the two major parties' favored combinations of abortion and social welfare policy. Concluding my empirical analysis, I also consider how the new knowledge generated by this study could affect support for social welfare policy, party competition, and the tone of the abortion debate.

1.2 Theoretical Perspective

1.2.1 Policy Tools and Human Behavior

This investigation draws its theoretical perspective from the literature on policy implementation and compliance. This literature studies governmental institutions' effectiveness at influencing individual behavior through policy tools, as well as the factors that influence choice of policy tool. It assumes that public policy aims "to get people to do things that they might not otherwise do; or it enables people to do things that they might not have done otherwise" (Schneider and Ingram 1990, p. 513). Though policy evaluation receives considerably less attention from political science than from other disciplines (Sabatier 1991; Schneider and Ingram 1990), several literatures that evaluate policy's impact on human behavior do exist. Political scientists have produced empirical evidence suggesting that policy has some effect on a variety of politically relevant behaviors, such as voter turnout (Knack 1995; Rosenstone and Wolfinger 1978), interstate moves of poor single mothers (Bailey 2005; Peterson and Rom 1989), welfare exits (Piskulich 1993), local government employee strikes (Perry and Berkes 1977),

consumption of cigarettes and alcoholic beverages (Johnson and Meier 1990; Licari and Meier 1997), and drunk driving (Durant and Legge Jr. 1993; Legge Jr. 1990).

Some scholars have argued that the growth in the number and diversity of policy tools with which government attempts to affect citizen behavior has been one of the most important developments of the American political system in the latter twentieth century (Dahl and Lindblom 1953; Salamon 1981; Schneider and Ingram 1990). Believing that some tools are more effective than others at producing compliance among their target populations but that existing theory had been inadequate for supporting this kind of analysis, policy scholars have attempted to classify policy instruments along a variety of dimensions that may affect citizen compliance with policy goals. In what two political scientists (Schneider and Ingram 1990) have called an important foundational piece for policy research, Salamon (1981) proposes that the analysis of policy tools has two questions at its core. The first concerns how the choice of one tool rather than another contributes to the effectiveness of a government program. The second concerns the political or other factors that influenced the selection of one type of tool rather than another.

This dissertation incorporates both questions. The bulk of its original data analysis attempts to gauge the potential effectiveness of economic assistance for mothers as a policy tool for reducing women's need for abortion. Where possible, I compare the estimated effectiveness of this tool, favored by political liberals, to alternative tools—regulation of abortion access and reliance on private rather than public forms of assistance to mothers—favored by conservatives. Political explanations for the present

balance of policy tools and analysis of a potential political constituency for an altered balance of policy tools serve as bookends around this investigation.

Policy tools can differentiate themselves by the assumptions they make about what motivates human behavior (Schneider and Ingram 1990). In their attempt to build a sounder theoretical foundation for the evaluation of public policy by political scientists, Schneider and Ingram (1990) identify five categories of tools—authority, incentives, capacity-building, symbolic and hortatory, and learning tools—and the motivations they assume—a desire to obey the law, utility maximization, resources and information or lack thereof, personal beliefs and values, and level of uncertainty based on past experience. Among other factors, choice of a tool depends on policymakers' beliefs about which of those motivations is most likely to produce the desired result among the target population, beliefs that undoubtedly have partisan, ideological, and cultural correlates. A law may rely on multiple policy tools at once.

Whether the particular policy tools under consideration in this dissertation—assistance provided to mothers to reduce the material and opportunity costs of parenthood—are best classified as capacity-building tools or positive incentives depends on presumptions about how strongly the target population is motivated toward childbearing. Both assume that pregnant women's decisions between abortion and childbirth are significantly motivated by economic factors. Incentive tools would assume that pregnancy outcome is the result of a rational cost-benefit calculation in which the options of abortion and childbirth are both available, and absent an intervention that substantially changes her cost-benefit structure, a woman has little reason to choose the option not taken. Capacity-building tools would apply to cases where motivation to

choose differently is not presumed to be lacking. What a woman lacks are the resources to carry out her desired course of action, such that her observed decision reflects the presence of barriers to one or more alternatives.

A group of American women whose choice of abortion results primarily from economic circumstances does appear to exist. In one recent study of abortion patients, 23 percent of respondents chose inability to afford a child as the primary reason for their decision. Overall, three-quarters of abortion patients indicated that inability to afford a child contributed to their decision. Significantly higher proportions of women selecting this option were young, never married, nonwhite, unemployed, and living on incomes below the poverty line (Finer et al. 2005). It is with respect to these women that welfare may function as a capacity-building tool in the context of abortion decisions, and it is primarily this target group that the present study has in mind. This dissertation considers whether current welfare state offerings appear to have altered the size of that group, and whether further expansion of the welfare state would allow more of these women who want to raise children to do so.

1.2.2 Economic Theories of Fertility: Why Social Policy Might Matter

I now turn to the theoretical groundwork for why we should expect policies that extend economic assistance to mothers to be associated with a greater likelihood of choosing birth rather than abortion among women experiencing an unintended pregnancy. Here, as in the rest of this study, I define "economic assistance" and "social welfare programs" broadly, referring to government programs that provide direct aid to women, as well as to laws that require others, such as an employer, to provide this aid. Though most people understand economic assistance or "welfare" programs as targeting

the poor, a larger system of social benefits protects the better-off, working population, insuring them against risks that could threaten their ability to support themselves through employment (Hacker 2002). I include these benefits as well, having in mind supports such as health care coverage, child care, and family leave.

This research does not take the view that women are only responding to economic incentives and disincentives when making childbearing decisions. These decisions are complex and deeply personal, as the challenges of motherhood go beyond simply getting by financially to questions of women's autonomy, their goals, their values, and their views on what is most important and meaningful in life (Feldt 2002). Study of economic incentives' potential to change the minds of women who would rather not bear children presents a less compelling case for research. From this author's interpretation of the existing literature, it also reflects perhaps too casual a view of the decision to terminate a pregnancy. Should this research identify a relationship between welfare generosity and the abortion decisions of more advantaged women, this could point to a variety of possibilities that would require further explanation. These include welfare's ability to address the barriers faced by poor would-be mothers, the nature of women's pregnancy decision-making, or simply a spurious correlation.

Constraint on reproductive choice also works in more ways than one. State and federal legislation involving parental consent for minors' abortions, waiting periods, informed consent requirements, clinic regulations, and bans on using public funds to pay for pregnancy terminations can create financial and legal hurdles to obtaining an abortion that some women may be unable to overcome until later in pregnancy (Henshaw and Finer 2003; Joyce and Kaestner 2000; Torres and Forrest 1988), when there are

heightened medical risks to the woman (Gold 1990; Grimes 1984) and fewer physicians available to do the procedure (Henshaw and Finer 2003). Restrictive abortion policy is also believed to decrease access to abortion by increasing costs to providers of abortion services (Matthews, Ribar, and Wilhelm 1997; Wetstein 1996). While the focus of this dissertation is on economic aspects of childbearing decisions, I do not mean to imply that these and other factors are theoretically or empirically unimportant. Quite the reverse is true, as I discuss later in this chapter, and all analyses conducted in this research will attempt to control for these personal and political aspects of childbearing decisions.

That said, there is substantial precedent for viewing childbearing decisions through an economic lens. Analysis of fertility within an economic framework took off during the 1960s with the work of Gary Becker and others (for an early review of this literature, see Schultz 1973a). This literature posits fertility decisions as part of a household production function. In this view, the decision to have a(nother) child or to practice fertility control comes down to whether the broadly defined costs of childbearing outweigh the broadly defined benefits. Fertility decisions are subject to constraints on both resources and time that do not necessarily affect fertility in the same way. Increases in resources like income may enable individuals to demand more children, for example, but in a potentially offsetting effect, women's time becomes more valuable as their potential earnings increase, and the opportunity cost of childbearing rises (Michael 1973; Schultz 1973a; Schultz 1973b).

If fertility is indeed sensitive to constraints on the resources and time of would-be parents, rather than strictly a matter of taste or chance, this raises the possibility that public policy may be inadvertently affecting women's decisions about their childbearing.

It also opens the door for explicit government efforts to influence fertility, something attempted by many European countries during the twentieth century in the hopes of reviving their falling birth rates (Legge Jr. and Alford 1986). Though it is debatable how strongly individuals weigh costs when making childbearing decisions, tools such as child tax credits, cash assistance, food and housing assistance, health care, child care subsidies, and paid parental leave surely defray the additional expenditures associated with childbearing. These tools also reduce the opportunity costs associated with childbearing by better enabling parents to stay in the labor force or in school after bearing a child. Viewed another way, welfare benefits make the payoff structure associated with childrearing more attractive than it would be in their absence (Akerlof, Yellen, and Katz 1996; Joyce and Kaestner 1996; Leibowitz, Eisen, and Chow 1986). Likewise, extending the application of this literature to unintended pregnancy, economic theory of this line predicted increases in poor women's abortions to result from the tightening of welfare eligibility and generosity after welfare reform (Klerman 1998).

Researchers typically draw from such economic models of fertility and the rational choice framework to model pregnant women's demand for abortion, considering it a form of fertility control (Garbacz 1990; Gohmann and Ohsfeldt 1993; Grossman and Joyce 1990; Jewell and Brown 2000; Joyce and Kaestner 1996; Leibowitz, Eisen, and Chow 1986; Medoff 2002; Powell-Griner and Trent 1987). According to this theory, abortion demand rises with the relative cost of childbearing, where cost encompasses monetary cost, psychic cost, and foregone opportunities. Thus abortion should be most common among poor, young, or highly educated professional women. Its utilization

should also be sensitive to public policy that affects the relative costs of abortion and childbearing.

One of the earliest articulations of welfare programs as capacity-building tools for would-be mothers and women considering abortion was the account of the Swedish welfare state reforms by scholar and policy maker Alva Myrdal (1968 (1941)). According to Myrdal, Sweden developed one of the world's most generous welfare states to increase its sagging birth rate while avoiding interventions that would make parenthood anything but voluntary. This strategy reflected Myrdal's belief that the decline in birth rates had been driven by reasons other than personal preference—that many women were undergoing unwanted abortions out of economic desperation, and many more were avoiding pregnancy solely because they could not afford children, especially in combination with work.

During the mid-twentieth century, social welfare policies became important and explicit components of many European countries' pronatalist population policy, though sometimes in combination with propaganda or changes in marriage and abortion law. The capacity-building tools[1] in these policy packages typically dealt with child care supply and affordability, leave time, and financial assistance to parents (Besemeres 1981). Some researchers have found that these economic policies did indeed reverse countries' declining birth rates and proceeded to sustain them over subsequent years (Buttner and

[1] Given many Eastern European countries' track records with respect to individual freedoms over this time period, a case could certainly be made that often these policies were not so much intended or interpreted as capacity-building tools, but rather, more cynically, attempts to bribe couples into conceiving and bearing children in spite of their existing preferences (incentive tools). This distinction is largely irrelevant to my broader point in illustrating the long history of the belief that welfare generosity could affect childbearing decisions. I raise it, however, to acknowledge the limited applicability of this policy research to the narrower questions in which I am interested: whether welfare generosity reduces abortions, and whether it does so in such a fashion that its beneficiaries are women who feel their economic disadvantage had prevented them from becoming mothers.

Lutz 1990; Frejka 1980; Legge Jr. and Alford 1986), while others are more guarded in their assessments (Gornick and Meyers 2003; Monnier 1990).

Though of questionable applicability to the present study given the difference from the American political climate and the goal of this research (see note 1), at least one study has attempted to compare the impact of economic supports (potentially capacity-building tools) to that of abortion restrictions (authority tools) on a related variable, birth rates. Results lend some support for the argument that voluntary policies affecting women's ability to afford children will more effectively reduce abortions than policies restricting women's ability to obtain legal abortions (Arons and Saperstein 2006). When comparing countries along their relative policy emphasis on economic supports for childbearing versus restrictions on abortion, Legge and Alford (1986) concluded that countries emphasizing economic supports were considerably more effective at increasing birth rates than countries emphasizing restrictions on abortion and other reproductive rights.

A case for social welfare programs as capacity-building tools in a reproductive rights context also comes from potential target populations. Grassroots activists among low-income women and women of color, particularly during the 1960s and 1970s, argued that government violated their right to bear children when it failed to provide them with health care and other economic resources necessary to properly raise a family (Dugger 1998; Nelson 2003; Solinger 2001). Historians claimed that the modern feminist movement alienated black women during its formative years because its emphasis on abortion and other means of freeing women from motherhood and the home did not speak to women of color, who largely worked drudge jobs and could not yet take motherhood

for granted (hooks 1984; Nelson 2003). With considerably more support this time from the reproductive rights movement (Joffe 1998), advocates for low-income women during the most recent round of welfare reform argued again that cuts in social welfare endangered their right to bear children (Jencks and Edin 1995; Roberts 1999).

1.2.3 Social Welfare and Abortion Decisions: What We Know

Though many presume that social welfare generosity should reduce abortions, we know very little about whether it actually does. Despite voluminous research on whether welfare benefits encourage nonmarital childbearing,[2] the academic community has not reached consensus on this issue (Moffitt 1997). Often this work considers only births, without estimating whether changes in abortion behavior may have mediated this relationship. Even some work on the welfare-nonmarital childbearing link that considers an intermediate stage representing the decision on whether to terminate an unintended pregnancy excludes welfare benefits as a predictor. This research limits the potential influence of welfare benefits to the subsequent decision of whether or not to marry (e.g., Lundberg and Plotnick 1995).

Two studies that did specifically consider abortion outcomes, rather than fertility more generally, offer modest support for the argument that welfare assistance may reduce abortion. An individual-level analysis of pregnant teenagers in one California town found that welfare receipt was positively associated with the decision to continue a pregnancy (Leibowitz, Eisen, and Chow 1986). In a three-state study, expansions in the eligibility of

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[2] This research does not concern itself with abortion. Its theory usually focuses on pre-conception rather than post-conception decisions.

pregnant women and infants for another social welfare program, Medicaid, were associated with substantial decreases in the probability that an unmarried, nonblack woman with no high school diploma would obtain an abortion (Joyce and Kaestner 1996).

No study appears to have examined child care policy's relationship to abortion, though several have indicated that expected or actual fertility decreases when child care is costlier or more scarce (Blau and Robins 1989; Blau and Robins 1991; Del Boca 2002; Lehrer and Kawasaki 1985; Mason and Kuhlthau 1992; Presser and Baldwin 1980; Rindfuss and Brewster 1996). Additionally, one suggests that child care subsidies and tax credits could substantially affect mothers' fertility and employment decisions (Blau and Robins 1989). Child care availability and affordability, including public subsidization of child care, are significantly associated with mothers' labor force status (Bainbridge, Meyers, and Waldfogel 2003; Blau and Robins 1989; Blau and Robins 1991; Gornick and Meyers 2003; Mason and Kuhlthau 1992; Presser and Baldwin 1980), appearing to help some women to maintain their employment and career aspirations in spite of parenthood.

Most other models that link welfare generosity and abortion demand have utilized state-level data, have concerned only cash benefit levels under the Aid to Families with Dependent Children (AFDC) program, and have left this variable on the periphery of other inquiries. This research has produced mixed findings, with one study finding that abortion rates and ratios were lower in states with higher AFDC benefit levels (Gohmann and Ohsfeldt 1993), others finding no relationship (Blank, George, and London 1996;

Meier et al. 1996), and another finding that while birth rates increased with AFDC benefits, abortion rates were unaffected (Matthews, Ribar, and Wilhelm 1997).

We know still less about the inverse argument, that cuts in welfare generosity should be associated with upticks in abortion levels. Recent research on the characteristics of abortion patients indicates that abortion rates increased among poor women over 1994-2001, and these women also increased as a percentage of women choosing abortion (Finer and Henshaw 2006; Jones, Darroch, and Henshaw 2002). Researchers initially pointed to the temporal coincidence of this trend with the implementation of welfare reform and predicted continued increases in poor women's abortions (Jones, Darroch, and Henshaw 2002). Additional descriptive data, however, show that at the same time, greater proportions of poor women experiencing unintended pregnancy are choosing birth rather than abortion, and so observed increases in poor women's abortion rates appear to be artifacts of increases in unintended pregnancy (Finer and Henshaw 2006). Some recent and more elaborate work concerning minors offers more support for the idea that welfare retrenchment could suppress childbearing. This research demonstrates that young teenagers' nonmarital childbearing has declined following welfare reform (Lopoo and DeLeire 2006; Offner 2005), but the data employed do not indicate whether abortion behavior was affected, or whether findings would apply to adults.

An alternative hypothesis, that welfare programs may increase abortions, remains plausible, though the balance of theory suggests that welfare programs should improve women's capacity to choose childbearing in those cases where economic need is the major reason why pregnancy is a problem. First, alongside any women who turn to

abortion because of their economic need may be women whose inability to pay prevents them from terminating a pregnancy. This latter concern motivates advocates of publicly funded abortion, but could also be alleviated by general welfare assistance. In countries like the United States where the means-tested welfare state is relatively small (Skocpol 1995) and most families cannot live on public assistance alone (Edin and Lein 1997), welfare programs may more successfully help women who desire abortion to fulfill their preferences than women desiring a child. Over the long term, child care assistance specifically could dampen fertility (possibly via abortion) by increasing mothers' attachment to the labor force (Presser and Baldwin 1980).

Another reason for a positive relationship between welfare participation and abortion concerns the orientation of the welfare state toward indigent women's childbearing. Departments of social services have notorious histories of intrusion into the intimate lives of their clients (Bell 1965; Mink 1998; Piven and Cloward 1993), and some suggest that the concern with nonmarital childbearing in the latest round of welfare reform is resulting in a similar though subtler pattern (Hays 2003). Welfare rhetoric and welfare rules, some argue, work together to discourage and devalue motherhood among those poor, often black, women who choose to deliver and raise their children (Hays 2003; Roberts 1999; Roberts 1995; Seccombe 1999). One scholar argued in the *Journal of Black Studies*, "ensuring that poor women do not reproduce has become one of the most popular welfare reform proposals of the 1990s" (Thomas 1998, p. 420).

Participants in programs for the able-bodied poor may be especially vulnerable to cues received from welfare offices since office culture and design emphasize strict adherence to program rules. Clients quickly learn caseworkers' power over them, and that

the best way to get what they need is to keep quiet and do as told (Soss 1999). On the other hand, any messages welfare recipients receive about their reproductive behavior need not be malintentioned. One study of a welfare office found social workers bending the rules to help the women they served, including arranging for money to fund some clients' abortions (Hays 2003). To some this may be suppression of fertility, but to others, empowerment in exercising one's own choices.

A third scenario is that welfare benefits may have no effect. While economic need ranks among the most important reasons why women choose abortion, most respondents give multiple reasons for the decision (Faria, Barrett, and Goodman 1985; Torres and Forrest 1988).

Pro-choice activists ultimately frame their case for legalized abortion as a matter of women's freedom and sexual equality. Since women's health and their ability to achieve their life goals are more profoundly affected by pregnancy and childrearing than are men's, control over whether and when to have children is believed to be an essential part of breaking down gendered power structures, upholding female autonomy, and protecting women's wellbeing (Goggin 1993a; Luker 1984). In individual-level research on abortion patients, responses tapping unreadiness to be a parent and concerns about the timing of a pregnancy rank with economic concerns among the top reasons behind the decisions of U.S. abortion patients (Faria, Barrett, and Goodman 1985; Glander et al. 1998; Torres and Forrest 1988). Torres and Forrest found that 76 percent of women selected concern about how a baby could change their lives as one reason for their decision. Nearly half of the women in the sample identified this option (16 percent),

unreadiness for the responsibility of parenthood (21 percent), or their youth or immaturity (11 percent) as the primary reason for terminating the pregnancy.

Many women's decisions to terminate a pregnancy are also closely tied to their thoughts about the desirability of single parenthood and other concerns about how continuing the pregnancy and raising a child could affect their most important relationships. This is a third salient bundle of concerns that appears to follow timing and finances in its importance to women. Half of the abortion patients in the Torres and Forrest study said that relationship issues or reluctance about being a single parent affected their decision, though smaller proportions of women cite similar concerns as the primary reason for their decision. Possible health problems for the woman or for the fetus affect smaller but nontrivial percentages of abortion decisions; about 4-6 percent of women in the three studies considered here cited one of these concerns as their primary reason for pregnancy termination (Faria, Barrett, and Goodman 1985; Glander et al. 1998; Torres and Forrest 1988).

It is logical to expect that religious denomination, orthodoxy, or intensity might affect women's decisions about abortion. Such variables factor prominently in explaining mass public opinion on the legality of abortion (Alvarez and Brehm 1995; Cook, Jelen, and Wilcox 1992; Himmelstein 1986; Jelen and Wilcox 2003; Strickler and Danigelis 2002), as well as public policymaking on abortion (O'Connor and Berkman 1995; Wetstein 1996). Descriptive data show that evangelical Protestants are under-represented among abortion patients, seculars are over-represented, and the distribution of Catholics and Jews among abortion patients reflects the underlying population distribution (Jones, Darroch, and Henshaw 2002). In the aggregate, the religious composition of a state's

population bears little relationship to abortion rates (Meier et al. 1996; Wetstein 1996). Abortion patients express generally positive views about the legitimacy of the option (Faria, Barrett, and Goodman 1985). At the same time, literature associated with the pro-choice movement stresses the commonality of the experience and the similarities of women choosing abortion to women choosing childbirth (Boonstra et al. 2006). Literature on abortion decision-making also often downplays the role of religious beliefs or beliefs about abortion in women's behavior, suggesting that women subordinate these principles to external circumstances when confronted with the reality of unintended pregnancy (Freeman 1978). Much of the above research, however, lacks any measure of religiosity beyond broad denominational preference, a shortcoming that I attempt to correct in my own consideration of these decisions.

1.2.4 Gaps in the Literature

In sum, existing literature indicates that many women choose abortion because of economic hardship, while for many other women another aspect of the economic cost of a child, opportunity cost, dominates their decision. Studies of public assistance programs' relationship with fertility suggests that these programs may have some pronatalist effects, though these are not overwhelming and will be more likely among some women than others. Clearly the literature does show that women's decisions are multi-faceted. We may reasonably expect that if there is a group of women who would make different pregnancy decisions if more economic assistance had been available to them, this group is probably relatively small.

Yet there are many missing links in this literature. Much of the research on abortion "demand" and on birth rates is conducted with aggregate data, making it

inappropriate to draw strong inferences about individual behavior. Most of the research does not or cannot distinguish between the decision to conceive a child (or at least not to contracept) and the decision about whether or not to carry an unintended pregnancy to term. Further, while financial need or concern that a baby would require a sacrifice of education or a career may be highly important reasons for women's decisions to terminate a pregnancy, we cannot assume that services addressing these concerns would be sufficient to relieve the multifaceted problems that unintended pregnancy presents in women's lives.

In these studies of the correlates and determinants of the decision to terminate a pregnancy, indeed "the question is raised as to whether or not some women might have made a different decision if some type of assistance or intervention were provided" (Faria, Barrett, and Goodman 1985, p. 98). Both studies of the decision-making process that raise this question proceed to dismiss it, on the grounds that women's reasons for choosing abortion are too numerous and complex for an intervention like child care assistance to make a difference (Faria, Barrett, and Goodman 1985; Torres and Forrest 1988). To my knowledge, the question raised by Faria and colleagues has not yet been empirically tested, much less answered convincingly. I aim to do that in the pages ahead.

1.3 Research Design

1.3.1 Data Overview

I approach my question with several sources of data. Each has its strengths and weaknesses, which I discuss in detail below, but by using multiple data sources I look to achieve some convergent validity in my findings.

Individual-level data on pregnancy outcomes and correlates of women's decisions are scant and are plagued by several problems that make them insufficient for answering my research question. Women severely underreport abortions in surveys, including two major surveys that include some questions about pregnancy outcomes, resources, and social service usage, the National Longitudinal Survey of Youth and the National Survey of Family Growth (Jagannathan 2001; Jones and Forrest 1992). Further, the women who most often underreport abortions—black women, young women, women with more positive attitudes toward childbearing, and in some surveys, unmarried women (Jagannathan 2001)—may also be more prone to unintended pregnancy, economic hardship, and/or welfare receipt. Data from studies of abortion patients are also difficult to acquire. This likely has much to do with patient confidentiality issues and the sensitive nature of abortion. To my knowledge, no published studies of abortion patients or women who carry an unintended pregnancy to term address how economic assistance could or did affect their decisions.

1.3.2 Baltimore Pregnancy Decision-Making Study

For this reason, I obtained Institutional Review Board approval to field my own study of women who have recently experienced an abortion or birth. In early 2005, I contacted abortion providers and pregnancy centers that provide alternatives to abortion to ask about the possibility of gathering data from their clients. All organizations in the Baltimore, MD metropolitan area for which I could find addresses were queried.[3] The

[3] Initially I also contacted offices in the Washington, DC metropolitan area. Though some of these offices also expressed willingness to participate, I later opted to narrow the sample to the Baltimore area. This eliminated the need to control for the different policies governing abortion and social welfare in Maryland, Virginia, and the District of Columbia. Additionally, this avoided a disproportionate weighting of the sample toward Baltimore that would have resulted had I decided to drop from participation two interested

study was eventually fielded during the summer and fall of 2005 at the offices of three abortion providers and four pregnancy centers in various neighborhoods of Baltimore City and its suburbs. Data were gathered by means of a self-administered questionnaire offered to clients by staff at the study sites. Among other things, the questionnaire asked women about the importance of various concerns at the time they were pregnant, about the resources they could have accessed if they chose to have and raise a baby, and about whether they might have made a different decision about their pregnancy if they had (or had not) received help in overcoming some important economic barriers to motherhood.

There were several reasons why I chose to build my sample through abortion providers and pregnancy centers. First, using abortion patients in the sample eliminated reporting concerns. The choice of pregnancy centers as the gateway to a sample of women undergoing childbirth may be less obvious. My primary reason for working through pregnancy centers was that these organizations are designed to serve women whose pregnancies are unintended or otherwise a problem. Beyond the practical difficulties involved, this target population would have been much more dispersed if I had attempted to collect the sample through the offices of individual obstetricians. Another alternative considered was to attempt to survey women in hospital maternity wards; this was rejected because of the intrusion this might create in a mother's life while recovering from childbirth, the biases that might result at a time when emotions are unusually keen, and the bureaucratic hurdles that would have to be overcome to conduct such a study. Public health clinics were a fourth study site that was considered for the childbirth sample. Since these clinics are designed to serve women with no health

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DC area study sites (one abortion provider and one pregnancy center) that had requested modifications to the survey that reflected their own interests.

insurance, however, this would most likely eliminate variation in one important independent variable and also ensure that the sample would be of low socioeconomic status. While I expected that the pregnancy center clientele would be less advantaged than the general population of mothers, the centers do not cater solely to low-income women.

Adoption agencies were considered as study sites, but it was not practical to expand the sample size to the degree necessary to accommodate this additional variation in pregnancy outcome. In making this decision I am missing only a very small share of women experiencing unintended pregnancies, since American women today rarely place babies for adoption.

Women were surveyed after their pregnancy had ended. This ruled out the possibility of mistakenly coding pregnancy outcomes because of changes of mind and avoided potential interference with the woman's decision. Abortion patients were asked to participate when returning to the clinic for an optional but recommended one-week post-abortion follow-up visit. Pregnancy centers do not maintain ongoing relationships with most women who come in for pregnancy testing and counseling. Many of these centers, however, encourage mothers to return after childbirth for gift layettes, and they also offer additional free assistance such as children's clothing, furniture, food, parenting classes, and support groups. Women who had given birth within the previous 12 months were asked to participate in the study when visiting centers for these kinds of services. Chapter five includes a discussion of the potential biases associated with this sampling design and the extent to which these biases were realized. Findings admittedly cannot be generalized to the entire population of U.S. women experiencing unintended pregnancy.

Even in spite of these defects, however, this study will add considerably to our knowledge about pregnancy decision-making and the role of social policy and services.

1.3.3 Fragile Families Study

My survey enhances and enriches the data available from existing sources, while some existing sources can also help to externally validate the results of some analyses performed on my sample. One of these sources is the Fragile Families and Child Wellbeing Study, conducted by Princeton University's Center for Research on Child Wellbeing and the Columbia University School of Social Work's Social Indicators Survey Center. Beginning in the late 1990s, researchers interviewed a sample of 4,898 mothers upon the birth of a child (the "focal child"). Most were re-interviewed when this child was 12-18 months old and again when the child was three. Mothers were questioned extensively about their receipt of public and private assistance and about economic hardships in their lives. They were also asked whether they had been pregnant since the birth of the focal child and about the outcome of those pregnancies. I draw most of my data from the one-year follow-up study, pulling data from the first and third wave files when appropriate. As the study was fielded in 20 cities in 15 states, I am able to consider interstate variation in abortion access, abortion policy, and social policy and how these variables may affect pregnancy outcome.

1.3.4 State-Level Data

Additionally, I compare these individual-level findings to the aggregate relationship between abortion rates and welfare policies. The main strength of this analysis is that it allows me to examine whether and to what extent policy change is

associated with changes in abortion levels over time. For this analysis, I employ data from the 48 continental states over the years 1988-2000. The American states are important arenas for abortion and social welfare policymaking, and policy in both areas evolved significantly over this study period. Most studies of the policy and other determinants of abortion rates utilize state-level data. Modifying this analysis to include social welfare policies allows me to contribute to the work that political scientists and others have already undertaken on how authority tools such as limitations on abortion access affect abortion rates.

1.3.5 Service Provider Database

Another data source used in this study takes a geographic approach to analyzing women's choices and alternatives. In 2005, I compiled a database of locations of abortion providers and providers of one particularly important supportive service for women who wish to choose otherwise, licensed child care. I gathered these data from a geographically and politically diverse sample of 12 states. After geocoding provider locations by street address and aggregating provider numbers up to the census tract level, I linked these counts to 2000 Census data on a variety of socioeconomic and other indicators. With these data, I attempt to estimate whether noticeable variation exists in women's spatial access to these alternatives, a concept that can be influenced by public policy and which in turn may relate to childbearing decisions.

1.3.6 Political Analysis

For my analysis of public opinion on abortion and social welfare and the behavior of potential constituencies for pro-life, pro-social welfare messages and policy, I rely on

the American National Election Study (NES). Conducted by the University of Michigan and frequently used in political science research, the NES is a nationally representative study of the politically relevant attitudes and behavior of voting-age Americans. Although this study has been conducted since 1952, I use the most recent cross-section, that of the 2004 presidential election year.

1.4 Outline

Chapter two provides the policy and political context of this study. I consider the balance of policy tools currently employed or advocated by those seeking to reduce U.S. abortions. I next turn to explanations for why authority rather than capacity-building tools dominate abortion policy, and, relatedly, why social welfare generosity is so rarely justified with pro-life arguments. Drawing from the extant political science literature, I discuss three contributing factors: the negative social construction of the potential beneficiaries of such policy, the positioning of the pro-life and pro-social welfare positions on opposite sides of a widening partisan divide, and way in which both of these factors may be connected to the feminist movement's definition of the abortion issue as a matter of choice, civil rights, and, by its counter-movements' presumption, an activist federal government.

My empirical investigation of the link between social welfare policies and abortion decisions begins in chapter three. Here, I consider how interstate variation and over-time change in the American states' welfare and abortion access policy related to changes in abortion rates over 1988-2000. I find evidence that the expansiveness of health care, child care, and family leave policy across states and over time contributed to reductions in abortion rates. Higher cash welfare benefits were associated with higher

abortion rates, but not with changes in this measure. Welfare generosity and limitations on abortion access both appear to reduce abortions, though the effect of the latter is more consistent.

Chapter four takes the analysis to the individual level, drawing on the Fragile Families data. This chapter tests the hypothesis that women's likelihood of choosing abortion will decrease as their access to and participation in social welfare programs increases. Data from a sample of predominantly low-income, urban mothers do not support this hypothesis. Welfare program participation and state welfare generosity are positively associated with the likelihood of choosing abortion. The existence and magnitude of this relationship, however, is mediated by the rules of state welfare bureaucracies and also varies by women's race and marital status. Limitations on abortion access appear to reduce abortions, while the nongovernmental safety net does not affect abortion decisions.

Chapter five repeats this analysis with data from my Baltimore area pregnancy decision-making study and provides a more detailed account of the role of economic need, social welfare policy, and the nongovernmental safety net in women's decisions. At the heart of this study is analysis of women's answers to the question of whether they would have made a different decision about the pregnancy if certain economic assistance had (or had not) been available. My findings suggest that the current public-private welfare state does prevent some abortions, and that expansion to a European-style welfare state would further reduce abortions, especially among low-income women and black women. At the same time, results also imply that the "pro-life" impact of welfare policy would be less than overwhelming. Economic need ranks as only one among many

factors in women's childbearing decisions, and the proportion of women who report they would have made different decisions about their pregnancy is not large.

Starting from the notion that pregnancy resolution may be related to proximity to providers supporting the desired pregnancy outcome, chapter six examines the relationship between neighborhoods' socioeconomic disadvantage and geographic access to abortion and child care services. I evaluate whether poor communities have fewer child care providers and more abortion providers than more advantaged communities. I find that somewhat fewer child care providers serve socioeconomically distressed neighborhoods, but that there is no relationship between neighborhood-level socioeconomic indicators and the presence of abortion providers, net of other factors such as urbanicity.

The remaining chapters deal with the political and policy implications of my findings. In the face of lukewarm empirical support for a relationship between welfare generosity and abortion reductions, chapter seven turns to the possibility that Democrats may nevertheless be able to alter the partisan balance of power by reframing social welfare as a pro-life issue. In this chapter, I examine the characteristics and political behavior of the most likely constituency for this kind of message, Americans who oppose legal abortion but support the welfare state. Findings suggest that messages aimed at this group may not very efficiently yield new Democratic votes. Though social welfare beats out abortion among pro-life, pro-welfare Americans when it comes to salience and awareness of party differences, low levels of education, income, political knowledge, and political participation distinguish this group of potential voters.

I conclude in chapter eight. In many ways, data analyzed in this study align with the status quo of abortion and welfare policy and politics. Political debates over welfare are largely independent of political debates over abortion. Likewise, the cases in which the root issues associated with low-income women's abortion decisions could be exclusively solved by welfare policy are rare. Welfare policy appears to be an effective capacity-building tool with respect to abortion decisions for some women, in some ways, and in combination with other supports. The pro-life movement's current dominant approach to abortion policy appears to meet the movement's goal of reducing abortions more efficiently than a capacity-building approach. Investment in capacity-building policy or in political messages of that tone holds promise for progress toward their respective policy and political goals. On the other hand, expected gain is modest considering both of these efforts would stretch the limits of the possible in American politics.

Chapter 2: Abortion and Social Welfare as Public Issues: Problems, Policy, and Partisan Politics

Why have capacity-building tools played such a minimal role in American abortion policy? Why have debates over the welfare state proceeded with so little reference to these policies' potential impact on abortion? This chapter takes up those questions, providing along the way the political and policy context for the study at hand. I offer three interconnected explanations for why capacity-building social welfare assistance has been virtually unincorporated into American abortion politics and policy. These concern the negative social construction of the target groups of such policy and the lack of elite, major-party support for this issue combination, which in turn depend upon how the abortion and social welfare issues have been defined by elites and interpreted by the mass public.

2 1 Contemporary Abortion and Social Welfare Policy

As noted in chapter one, abortion policy battles are fought chiefly over the establishment of legal and administrative barriers to obtaining an abortion. Figure 2.1 provides examples of the contemporary policy agenda of pro-life organizations. The first list in the figure represents the perspective of a leading pro-choice organization. NARAL Pro-Choice America's compilation of "Key Anti-Choice Issues" (NARAL Pro-Choice America Foundation 2005) is the data source most commonly used by political scientists and others studying abortion policy. The second list represents the perspective of a leading pro-life organization, the National Right to Life Committee (NRLC). As NRLC

Figure 2.1 Contemporary Abortion Policy

NARAL Pro-Choice America "Key Anti-Choice Issues":

- *Abortion Bans*: Outlaw abortion at various stages of pregnancy, or ban particular types of abortion procedures.
- *Biased Counseling and Mandatory Delays*: Require that abortion providers present specific information, often pertaining to risks of the abortion procedure, fetal development, and/or alternatives to abortion, and that a waiting period pass before the abortion can be performed.
- *Counseling Bans and "Gag Rules"*: Prohibit public employees or organizations receiving public funds from providing abortion information or referrals.
- *Insurance Prohibition for Abortion*: Prevents or limits health insurance coverage of abortion services.
- *Low Income Women's Access to Abortion*: Restricts use of public funds to pay for abortion services, most typically through the Medicaid program.
- *Restrictions on Young Women's Access to Abortion*: Require notification or consent of at least one parent before abortion can be performed on a minor.
- *Targeted Regulation of Abortion Providers*: Licensing, reporting, health, building, and other codes applying specifically to abortion providers.

National Right to Life Committee Issues/State Legislative Highlights:

- *Abortion Clinic Regulations*: Licensing, reporting, health, building, and other codes applying specifically to abortion providers.
- *Abortion Nondiscrimination*: Prohibit differential legal treatment of health care facilities and professionals that refuse to refer for, cover, fund, or perform abortions.
- *Born-Alive Infants*: Any living infant is legally a person once completely expelled from the mother, even if the infant is born alive as a result of a failed abortion attempt.
- *Harvesting Baby Body Parts*: Ban research/publicly funded research on aborted fetuses.
- *Helping Women in Crisis Pregnancies*: Publicly fund pregnancy care centers and maternity homes.
- *Human Embryos*: Prohibit cloning research that involves the destruction of human embryos; ban public funds for stem cell and cloning research that involves the destruction of human embryos, support public funding of stem cell research that does not harm embryos or other donors, such as newborns' umbilical cord blood.
- *Innocent Child Protection Act*: Prohibit execution of pregnant women.
- *International Issues*: Oppose public funds for governmental and nongovernmental organizations that promote or perform abortions overseas, oppose provisions in United Nations treaties that increase access to abortion.
- *Pain of the Unborn*: Prior to performing a late-term abortion, abortion providers must provide woman with specific information about fetus's ability to feel pain, and offer her the option for fetal anesthesia.
- *Parental Involvement*: Require notification or consent of at least one parent before abortion can be performed on a minor, make it a crime to transport a minor across state lines for an abortion to avoid parental involvement law in home state.
- *Partial-Birth Abortion Ban*: Outlaw a particular abortion method.
- *Unborn Victims of Violence Act*: Persons can be charged separately for harming a fetus while committing a violent crime against a pregnant woman.
- *Woman's Right to Know*: Require that abortion providers present specific information, often pertaining to risks of the abortion procedure, fetal development, and/or alternatives to abortion, and that a waiting period pass before the abortion can be performed.

does not publish a particular agenda apart from its federal legislative scorecard, I compiled this agenda using those abortion-relevant policy issues listed on the front page of the organization's web site (National Right to Life Committee 2006) or in a summary of 2005 state legislative accomplishments published in the organization's newspaper (Andrusko 2005). While I leave policy names in each organization's terminology, policy summaries are my own.

Most of the policies in figure 2.1 represent "authority" tools or "symbolic and hortatory" tools (Schneider and Ingram 1990). They mandate or proscribe particular behaviors, or appear aimed at communicating a particular message, in these cases about the personhood of the fetus or unborn child, or about potentially negative aspects of abortion. Social welfare programs for low-income mothers make no appearance, though the National Right to Life Committee does mention six states' provision of funds to organizations that promote abortion alternatives as a "new thrust" in pro-life state legislation (Andrusko 2005).

The pro-life movement has not entirely neglected capacity-building tools in its efforts to reduce abortions. One recent example includes the proposed Women and Children's Resources Act, which would have allocated to states federal funds that states could disburse to pro-life "pregnancy care centers." These organizations assist mothers in acquiring the economic resources to raise a child or in placing a baby for adoption (Townsend 1999). At this time of this writing, Feminists for Life of America was promoting the Elizabeth Cady Stanton Pregnant and Parenting Student Services Act, a bill to provide federal grants to colleges to open offices for pregnant and parenting students. The bill also required that funded institutions host forums on pregnancy

resources and set goals for expansion of services and policies pertaining to child care, health coverage, leave time, flexible scheduling, and other issues (Feminists For Life of America 2005). A related multi-group initiative, the "Women Deserve Better" [than abortion] campaign is currently underway and appears to be led by the U.S. Conference of Catholic Bishops. While this is primarily an advertising campaign and does not appear to advocate specific legislation, slogans reference society's obligations to assist women in need as well as a belief that no woman should have to face consequences such as poverty or an end to her schooling as a result of pregnancy (Cleaver 2003).

The most recent Republican party platforms have also addressed some of the economic aspects of abortion alternatives. They call, for example, for aid to maternity homes and "crisis pregnancy programs," and acknowledge the Bush administration's actions to cover the unborn under the State Children's Health Insurance Program (Republican Party 2004; Sanbonmatsu 2004). Stated the 2004 platform, "Our goal is to ensure that women with problem pregnancies have the kind of support, material and otherwise, they need for themselves and their babies, not to be punitive toward those for whose difficult situation we have only compassion." Generally, however, advocacy of capacity-building policy tools of the types discussed above has proceeded with little fanfare and relatively little legislative success, and does yet not appear to be a political priority of the pro-life movement and its allies in government. Further, these efforts bypass government as a service provider, focusing instead on the provision of public funds to nongovernmental organizations.

Of course, federal, state, and sometimes local governments provide social welfare assistance to low-income families more generally, often with eligibility rules that target

assistance to mothers and their small children. Temporary cash assistance, health insurance, child care subsidies, food and nutrition programs, and public housing and housing vouchers constitute some of the main types of welfare aid potentially available to qualifying low-income pregnant women and mothers. Low-income working people can apply for the Earned Income Tax Credit, and eligibility thresholds are higher when those individuals have dependent children. Much American welfare effort, however, takes the form of tax expenditures or operates through private employers (Hacker 2002). Health insurance in particular is a privatized benefit for all but the very poor and the very old. Parents cannot take advantage of certain subsidies such as per-child tax credits and child care tax credits until they have earned a certain amount of taxable income. Federal law protects working women's right to job-protected maternity leave, but this leave is unpaid and applies only to large employers (Committee on Family and Work Policies 2003).

In recent years, the American welfare state has both expanded and contracted, depending on the program area. From the 1990s onward, the U.S. state and federal governments have expanded family leave laws as well as spending on child care (Committee on Family and Work Policies 2003; Waldfogel 1999). Creation of the State Children's Health Insurance Program in 1997 followed late 1980s and early 1990s expansions in the Medicaid program in a series of efforts to expand Americans' access to health care (Joyce and Kaestner 1996; Volden 2006). Meanwhile, under federal and state welfare reform efforts during the 1990s, access to cash welfare assistance has grown more restrictive and benefits less generous (Lieberman and Shaw 2000; Soss et al. 2001). Debates over these policies and programs have generally proceeded wholly outside the

abortion debate, save for some pro-life groups' role in fighting the proposed welfare reform family cap, discussed in chapter one.

2.2 Explanations

2.2.1 Social Construction of Target Groups

Schneider and Ingram (1993) argue that the social construction of the group at which a policy is aimed influences policymakers' choice of tool. Social construction refers to recognized characteristics of a group that distinguish its members from other individuals, and to the value-laden symbols, stereotypes, and images society assigns to that group. Policies directed at groups with negative social constructions tend to incorporate punitive elements, while policies aimed at more favorably constructed groups offer more benefits to those populations.

Little has been written on the social construction of women having or seeking abortions, and on its manifestation in American politics. Considering that the abortion rights movement has framed much of its argument in terms of choice and freedom (Luker 1984; Solinger 2001; Tribe 1990), perhaps one reasonable role associated with these women is that of "choice maker."

The assessments of several scholars and commentators suggest that on balance, any existing "social construction" of abortion seekers is fairly unsympathetic. The term "choice" may imply that the decision is casually made (Mathewes-Green 1994), especially considering that pro-life rhetoric centers on the humanity of the unborn, and the two sides of the abortion debate share little common language (Luker 1984; Tribe 1990). Those that oppose abortion, scholars argue, view abortion as an irresponsible and immoral choice, a rejection of gender roles and the natural order, and a means of

avoiding responsibility for one's actions (Lakoff 2002; Luker 1984). While Americans holding more moderate or ambivalent views on abortion may have a more benign view of women who choose it, intellectuals on opposite sides of the abortion divide have suggested that choice rhetoric may also be promoting a less sympathetic public image of women considering abortion (Mathewes-Green 1995; Solinger 2001). The language of choice, they argue, leads society to overlook that women who choose abortion may have very real unmet needs and effectively excuses governments, employers, and other institutions from offering capacity-building assistance to women who do or would otherwise like to raise children. Thus a hesitancy not to address abortion with capacity-building policy tools need not be confined to those with particularly strong anti-abortion views.

Public opinion data on the circumstances under which Americans support legal abortion indirectly contribute to this social construction explanation for why capacity-building tools have had so little role in American abortion policy. Support for legal abortion varies greatly when respondents are asked to consider the circumstances under which a woman seeks abortion (Alvarez and Brehm 1995; Cook, Jelen, and Wilcox 1992; Ladd and Bowman 1999). Large majorities of the public support legal abortion in cases of rape, incest, or medical complications for the woman or fetus, but fewer Americans consider poverty a valid reason for a legal abortion. In 1998, 42 percent agreed with a National Opinion Research Center question on the legality of abortion when the woman had a very low income and could not afford any more children (Ladd and Bowman

1999),[4] while in 2003, only 35 percent offered support on a similar Gallup poll question (PollingReport.com 2006).[5] Most Americans support making abortion legal and available, but do not want it "undertaken lightly" (Ladd and Bowman 1999, p. 9). They also support stricter limits on the procedure than are currently in place (Ladd and Bowman 1999; Pew Research Center 2005).

These findings, coupled with one other observation, suggest that many Americans who are otherwise moderate on abortion may believe the procedure is being used too casually, and thus may lean toward a negative perception of women seeking abortions. When asked in 2005 if, irrespective of one's opinion on whether abortion should be legal, it would be "a good thing to reduce the number of abortions performed in the United States," 59 percent voiced their agreement (Pew Research Center 2005).[6]

Given that Americans' views about the deservingness of benefit recipients mediates mass and elite support for various social welfare programs (Cook and Barrett 1992; Gilens 1999; Katz 1989), the lack of serious proposals or public pressure to extend economic benefits to this group is unsurprising.

The social construction of target groups also provides a plausible explanation for the related question of why a pro-life argument has not found its way into welfare policy rhetoric. A key stereotype about welfare recipients, believed to be linked to the increasing

[4] Exact question wording is: "Please tell me whether or not you think it should be possible for a pregnant woman to obtain a legal abortion if the family has a very low income and cannot afford any more children?"
[5] Exact question wording is: "Now I am going to read some specific situations under which an abortion might be considered. For each one, please say whether you think abortion should be legal in that situation, or illegal. How about . . . when the woman or family cannot afford to raise the child?"
[6] Exact question wording is: "Regardless of whether or not you think abortion should be legal, do you think it would be a good thing to reduce the number of abortions performed in the United States, or don't you feel this way?" Fifty-nine percent called reducing abortions a "good thing," while 33 percent did not feel that way. Approximately 1.3 million abortions are performed annually in the United States (Finer and Henshaw 2003).

proportion of black women among welfare clients from the 1960s onward, holds that welfare recipients are not fit to be mothers (Bensonsmith 2005). Some observers of the mid-1990s welfare reform debate allege that in reducing assistance and enacting numerous provisions designed to penalize out-of-wedlock childbearing, conservative policymakers sought to the keep poor women from reproducing (Roberts 1999; Thomas 1998).

2.2.2 Party Platforms and Elite Leadership

Scholars of the policy agenda point to the importance of a "policy entrepreneur," in seeing that a proposal reaches the government's decision agenda. This individual develops and promotes an idea over time, and plays a pivotal role in linking a perceived problem to a workable solution and to favorable politics, all at the opportune moment (Kingdon 1995). When it comes to the expansion of social welfare programs as a form of abortion policy, the likelihood of finding such a well-positioned individual and a favorable politics diminishes substantially when considering that a pro-life, pro-social welfare leaning is inconsistent with the platforms of the two major U.S. parties. Though officially favoring expansions in social welfare programs, the pro-choice Democratic party may risk offending its core supporters in the abortion rights movement by promoting welfare programs as even voluntary alternatives to abortion. The Republican party, seemingly a still less hospitable home for such a proposal given its historic desire to contract the welfare state, would risk alienating the large majority of its adherents who are fiscal conservatives, and also perhaps disturbing pro-life supporters who may fear that such a approach may symbolize a moderation of the party's opposition to legal abortion. The elites of abortion politics, after all, appear reluctant to entertain even the appearance

of compromise on their issue (Tribe 1990). The ability to pursue ideologically extreme goals is believed to be what keeps political party (Aldrich 1995) and interest group (Mansbridge 1986) elites motivated to contribute disproportionately to collective efforts.

Why did neither of the major parties adopt a pro-life, pro-welfare platform? Exploration of this question may be worth some attention since any shift in abortion policy toward a capacity-building approach would most likely need a major-party endorsement.

2.2.3 Party Cleavages on Social Welfare and Abortion

It is no secret that American politics since the 1970s has been characterized by increasing ideological and partisan polarization at both the elite and mass levels (Abramowitz and Saunders 1998; Hetherington 2001; Rohde 1991), and this has something to do with the emergence of moral and cultural concerns such as abortion as political issues (Adams 1997; Layman 2001). Others have masterfully articulated how these developments came about. In the late 1960s and early 1970s, organized constituencies such as feminists and youth began to agitate for a liberalization of American policy on cultural issues. Democratic presidential candidates, most notably George McGovern and Eugene McCarthy, expressed openness to these constituencies' views in the hopes of gaining an edge over the favorite of the party's traditional blue-collar labor base. Racial politics had already begun to weaken the New Deal coalition, particularly in the South, but these disaffected Democrats were largely calling themselves independents, rather than joining the GOP (Carmines and Stimson 1989; Katznelson 1989; Layman 2001). Meanwhile, seeking to reverse the path to permanent minority status that they had been traveling since the New Deal, Republican strategists searched

for potential converts and for an issue that could change their electoral fortunes (Layman 2001; McKeegan 1992).

Political minorities can hope to turn the tide by introducing and taking positions on issues that cut across the existing partisan cleavage—in theory, the new conflict displaces the old conflict, and activists and voters may reorder their party attachments and voting behavior accordingly (Carmines and Stimson 1989; Schattschneider 1960). Abortion, arguably the most salient item on a culturally conservative agenda that included such issues as school prayer, gay rights, the Equal Rights Amendment and women's liberation more generally, was such a cross-cutting issue and fit the bill for the Republicans (McKeegan 1992; Shafer 1991). Members of many groups associated with the Democrats' New Deal coalition, including Catholics, Southerners, and blue-collar union workers (Axelrod 1972) tended to hold more traditional positions on this and other cultural issues (McKeegan 1992; Melich 1996). Evangelical Protestants also were viewed as a source of potential converts. Democrats had enjoyed a political advantage among this lower-status and largely apolitical group, but its leadership was concerned about cultural liberalism and was attempting to organize politically (Layman 2001; Wald 1997). In the potential mobilization of cultural conservatives, socially conservative Republican strategists saw an opportunity to increase their own faction's heretofore limited influence in the party, as well as a real chance to crack the Democratic majority. Staking out a clear culturally conservative position could risk turning off members of the party's dominant bloc—fiscal conservatives who largely also took a laissez-faire approach to moral politics—but Republicans were already political losers, and they closely valued party unity (McKeegan 1992; Melich 1996).

Over time, both parties' platforms and the attitudes of party elites diverged on abortion, with Democrats becoming increasingly committed to a pro-choice position and Republicans to a pro-life position (Adams 1997; Carmines and Woods 2002; Sanbonmatsu 2004; Wolbrecht 2000). Meanwhile, social welfare issues continue to distinguish and polarize the two parties and their mass adherents (Abramowitz and Saunders 1998; Fiorina, Abrams, and Pope 2005; Layman and Carsey 2002; Rohde 1991).

This story of the present partisan cleavages does not go far in explaining why the process initiated as it did, with the pro-social welfare Democrats adopting the culturally liberal, rather than the culturally traditional, position on abortion. After all, many cultural traditionalists were concentrated among the Democratic masses when *Roe v. Wade* was decided. When mass public opinion polling on abortion began in the early 1970s, more Democrats than Republicans were pro-life, while Democratic elites showed somewhat more support for abortion rights than Republican elites (Adams 1997; Carmines and Woods 2002; Sanbonmatsu 2004). Meanwhile, on women's issues more generally, the feminist agenda had enjoyed more support from the Republican party for much of the twentieth century (Freeman 1987; Sanbonmatsu 2004; Wolbrecht 2000). Some scholars continue to charge that the Republican party's support for restrictive abortion laws contradicts its overarching philosophy of limited government, and that policymakers whose opposition to abortion truly stems from concern for unborn children should naturally support a host of social welfare measures that also protect those children after birth (Schroedel 2000).

Yet the alignment of the parties' positions on abortion and social welfare makes political sense and becomes more philosophically plausible when viewed in light of scholarship on the modern women's movement more generally. While a single-issue abortion rights movement does exist independently of the broader feminist movement, most feminist organizations by the early 1970s had adopted explicitly pro-choice positions, and this issue came to be one of the more salient components of the broader women's rights agenda (Wolbrecht 2000). This literature on women's issues offers several explanations, grounded in ideas about issue definition and party culture, for the development of the present partisan alignment of the abortion and social welfare issues.

One explanation, offered by Freeman (1987), cites the structure and culture of party organizations. Organized interest groups wield considerably more influence in the Democratic party, where power flows from the bottom up, institutional rules facilitate the formation of special caucuses and their involvement in party business and policymaking, and the party conceives of itself as a coalition of groups (see also Axelrod 1972 on the perception of Democrats as a coalition of minorities). Moreover, while feminists were reorganizing themselves in the 1960s, Democrats were rewriting their rules to encourage more proportional representation of a variety of formerly marginalized, politically ascendant demographic groups among convention delegations, including racial minorities and youth. Feminists, who were pro-choice at the organizational level, came to find the Democratic party a much more hospitable environment for expanding their influence than the Republican party, whose concentration of power in the upper echelons of the organization hierarchy and whose emphasis on loyalty and the presentation of a united front discouraged and limited the influence of feminists as feminists. As with other

groups in their areas of interest, once feminists achieved some legitimacy and recognition within the Democratic party, they were given virtually total control over party positions on “women’s issues.” This way, the Democratic platform gained and maintained a pro-choice plank in spite of the large numbers of pro-life Democrats.

While not disagreeing with this explanation, Wolbrecht (2000) emphasizes the changing definition as women’s issues over this time period as a part of a more complete account of why Democrats and Republicans changed sides with regard to feminist positions. To some extent, she suggests, women’s issues can be understand within the same scope-of-government rubric from which social welfare issue positions are derived. Prior to the advent of the contemporary, second-wave feminist movement in the 1960s and 1970s, women’s issues debates had been framed in terms of what government could do to protect women, given their special spheres and vulnerabilities as women. The Democrats championed cash welfare assistance for mothers and children, maternal-child health programs, and protective labor laws applying specifically to female employees. Democrats initially resisted the Equal Rights Amendment (ERA), as legal analysts predicted that the increase in gender-neutral treatment required by this amendment would invalidate women’s labor legislation. Meanwhile, the ERA was more consistent with Republicans’ more libertarian position, in that it would circumscribe government’s ability to treat women differently and regulate the economy.

Over time, the emerging definition of abortion and the evolving definition of women’s rights more generally created dissonance between the feminist agenda and the pro-business, laissez-faire philosophy. Interpretation of the ERA changed to emphasize the expansion, rather than the restraint, of federal government activity (Mansbridge 1986;

Wolbrecht 2000), and the simultaneous emergence of abortion as an issue reflected similar themes. Pro-choice advocates defined abortion as an issue of civil rights and women's equality, envisioning dramatic changes in American society and women's place as a result of the procedure's legalization (Luker 1984). Some legal scholars further argued that if poor women could not meaningfully exercise their rights to abortion (and therefore to gender equality), government funding of abortion was normatively or even legally imperative (Graber 1996; Mansbridge 1986).

Meanwhile, many abortion opponents were traditionalists who equated the pro-choice position and the broader feminist vision of which it was a part with government interference in matters of hearth and home, and a threat to their own way of life (Luker 1984; Wolbrecht 2000). The attempts of the pro-choice, feminist movement to link itself to the ongoing civil rights movement further facilitated the alignment of pro-choice interests with the Democratic party and the pro-life countermovement with the Republican party (Wolbrecht 2000), as racial issues by this time had developed into a defining partisan cleavage (Carmines and Stimson 1989). Support for the feminist agenda, on which abortion became a key item, therefore seemed to be a natural extension of Democrats' growing association with the interests of marginalized groups (Wolbrecht 2000). Others argue that Democratic support for a pro-choice plank, expansionist welfare policy, and a host of other signature issues are united by the motif of government as a "nurturing parent" (Lakoff 2002). Once the abortion issue and its pro-choice supporters are defined in this way, the pro-life position appears more congruent with Republican principles of limited government.

That the parties have aligned as they have on these two issues also makes sense in light of the elite-driven nature of American party politics. The emphasis on feminists' reframing of women's issues in the 1960s as a matter of civil rights, equality, and government activism, as well as both quantitative and qualitative histories of developments of party platforms and partisan polarization in the postwar years casts elites as the first movers in determining how this new issue, abortion, would fit in with the existing dominant partisan cleavage, that of social welfare. Political elites are drawn disproportionately from the most educated ranks of American society, and education, even more so at the time of *Roe v. Wade* than at present, is associated with a pro-choice orientation (Jelen and Wilcox 2003). Thus Democratic elites were much further to the cultural left than their mass identifiers, and also appeared to care more about these issues. Republican elites, meanwhile, were also located slightly to the left of their mass identifiers on cultural issues, but held economic issue positions well to the right of adherents in the mass public (Shafer and Claggett 1995).

That economic conservatism more so than cultural issues appeared to distinguish Republican elites from their masses explains the lack of any GOP movement to adjust its welfare position in a way that some believe is more philosophically consistent with its pro-life position. Economic conservatism bound Republicans together while the cultural issue cleavage emerged, Republican feminists identified as Republicans first and feminists second (Klatch 1987; Melich 1996), and the party prided itself on presenting a united front (Melich 1996). Even today, despite the rhetoric of "culture wars" and a bitter division of Americans into "red" and "blue" camps, the old cleavage over economic and social welfare issues remains alive and well in American mass partisan politics (Layman

and Carsey 2002), while the culture war rages chiefly among the political elite, and between the most religious and most secular wings of the mass public (Fiorina, Abrams, and Pope 2005; Layman and Green 2006).

2.3 Changes to the Democratic Message?

So far, this discussion of issue alignment, polarizing parties, and the nation's presumably dim political images of abortion seekers and welfare recipients appears to minimize the *political* relevance of this project's primary research question. There is nothing mysterious about why authority, rather than capacity-building, tools dominate American abortion policy, or why neither major American party has adopted a pro-life, pro-social welfare platform since abortion emerged as a national issue. Even if the following analysis revealed a strong and consistent link between welfare generosity and reductions in abortion levels, what reason would we have to believe that American policymakers would expand the welfare state or alter the balance of abortion policy tools accordingly?

The answer at this point appears to be, very little. On the other hand, recent developments in Democratic party politics provide the earliest of hints that some activists may more seriously consider minor modifications in the party's *message* on abortion. While the party's support for abortion rights will not be affected in practice, a change in the party's rhetorical approach to the abortion issue may bring along with it more serious attempts to add capacity-building tools to abortion policy, as well as attempts to incorporate pro-life language in the party's defense of the welfare state.

Though political scientists have voiced skepticism over the role of the "values voter" in the Republicans' 2004 election victory (Abramowitz 2004; Burden 2004;

Hillygus and Shields 2005), the media and Democrats themselves speculated in its wake that in order to regain majority status, the Democrats needed to reach out to those pro-life, culturally conservative constituencies that the party is believed to have alienated (Kirkpatrick 2004; Milligan 2004). A flurry of recent political commentary has suggested that welfare expansion would be "pro-life," enabling more low-income women to carry pregnancies to term (Arons and Saperstein 2006; DeLauro 2006; Dionne 2005; Roche 2004; Stassen 2004; Wallis 2004). Further, religious leaders such as evangelical Jim Wallis and Catholic Richard John Neuhaus rank among those who have projected that Democrats could pick up additional votes by reframing social welfare as a pro-life issue or modestly softening the party line on abortion (Kirkpatrick 2004; Wallis 2004).

The "95-10 Initiative" (reduce abortions by 95 percent over 10 years) promoted by Democrats for Life of America (2005) previews the modest shift in abortion policy that might accompany such a change in the Democratic message. This agenda, summarized in figure 2.2, contains some abortion access limitations that are favored by pro-life conservatives but likely will not earn the endorsement of the Democratic party. Proposals fall well short of the European-style welfare state, but this program, in contrast to the mainstream pro-life agenda, is dominated by capacity-building policy tools and contains several distinctly Democratic, pro-social welfare elements, including calls for increased funding for the WIC nutrition program and expansions in eligibility for public health care coverage.

I return to Democratic politics in chapter seven, when I examine the characteristics and political behavior of the most likely constituency for a modified Democratic message, Americans who combine pro-life and pro-social welfare positions.

First, however, the next four chapters address the prior policy compliance question of whether welfare generosity affects, or would affect, the childbearing decisions of its target population. When possible, I compare this strategy's impact to that of the authority-tool approach favored by the mainstream conservative, pro-life movement.

Figure 2.2 Democrats for Life of America "95-10 Initiative"

"The 95-10 Initiative is a comprehensive package of federal legislation and policy proposals that will reduce the number of abortions by 95% in the next 10 years. While both Democrats and Republicans talk about reducing the number of abortions, Democrats for Life of America offers real solutions to make this goal a reality. With bold new ideas, sound research and policy arguments, the 95-10 Initiative contains proven policy suggestions to dramatically reduce the number of abortions in America."

- *Federal Funding for Toll-Free Number/National Public Awareness Program:* Finance advertising campaigns and toll-free numbers in each state that connect pregnant women to organization offering resources and adoption assistance.
- *Conduct a National Study & Update Abortion Data:* Direct National Institutes of Health to conduct a study on the reasons women choose abortion.
- *Federal Funding for Pregnancy Prevention Education*
- *Federal Funding for Abortion Counseling and Daycare on University Campuses*
- *Provide Accurate Information to Patients Receiving a Positive Result from an Alpha-Fetoprotein Test:* Provide patients undergoing prenatal genetic testing with information on the chance of false positives.
- *Make Adoption Tax Credits Permanent*
- *Ban Pregnancy as a "Pre-Existing Condition" in the Health Care Industry*
- *Require Adoption Referral Information:* Applies to pregnancy counseling centers that receive federal funding.
- *Women's Right to Know:* Require abortion providers and pregnancy counseling centers to offer to women specific information on abortion and its potential adverse health effects.
- *Provide Ultrasound Equipment:* Provide grants to nonprofit organizations for purchasing this equipment and offering free ultrasounds.
- *Increase Funding for Domestic Violence Programs:* Increase federal funding for existing programs in order to expand outreach and shelter for pregnant women and their children.
- *Fully Fund Federal WIC Program*
- *Provide Grants to States to Help in the Promotion and Implementation of Safe Haven Laws:* Nearly every state has a "safe haven" law, which designates certain public places where mothers can leave unwanted infants without penalty.
- *Require Counseling in Maternity Group Homes:* Require adoption counseling and parenting classes in homes that receive federal funding.
- *Require SCHIP to cover pregnant women:* Expand Medicaid and the State Children's Health Insurance Program cover pregnant women and infants under age one.

Note: Policy names reflect group's terminology.

Chapter 3: Welfare Generosity, Abortion Access, and Abortion Rates: A Comparison of State Policy Tools

I begin my investigation at the state level. Since a series of U.S. Supreme Court decisions in the 1980s affirmed states' authority to regulate access to legal abortion, political scientists and others have shown interest in how within- and between-state variation in abortion policy affects abortion usage (e.g., Goggin 1993a; Hansen 1980; Meier et al. 1996; Wetstein 1996; Wetstein and Albritton 1995). Theoretical explanations of why state law should affect a matter so personal as pregnancy termination argue that public policy can adjust the cost calculus of potential abortion suppliers and potential abortion seekers. On the demand side, abortions should decrease as the cost of abortion, relative to the cost of childbearing and parenthood, increases.

This latter figure is not static. States actively legislate on a variety of topics that can alter the financial and opportunity costs of would-be parents. Among these are such welfare-state matters as means-tested assistance and private benefits that employers may be required to provide. The role of welfare generosity in models of abortion rates has received only limited attention, however, and has been narrowly defined by those studies that do include it.

Considering an array of social welfare policies, this chapter asks: is welfare generosity related to abortion rates? More specifically, are states with more expansive policies on health care, child care, family leave, and income support seeing larger reductions in abortions? I find that they are, but that the effect of welfare generosity varies by type of welfare policy instrument. Policies expanding access to child care, health care, and family leave, appear to have contributed to reductions in abortion levels.

States with more sizeable cash welfare benefits have significantly higher baseline abortion rates, but cash welfare generosity is unrelated to changes in abortion levels over time.

3.1 Abortion Demand at the State Level

Most models of aggregate abortion demand assume that abortion levels exhibit some sensitivity to the relative costs of abortion and childrearing. As states increase the number of steps that must be taken before pregnancy termination can be provided, abortion becomes increasingly costly to supply. For pregnant women, the direct costs of authority policy tools such as parental involvement or information provision requirements, waiting periods, the denial of public funds for poor women's abortions, and the targeted regulation of abortion facilities, combine with indirect costs from reduced supply to make abortion more costly and less attractive. With some exceptions (Medoff 2002; Meier et al. 1996), most studies do find that at least some of these policies are associated with reductions in abortion rates (e.g., Blank, George, and London 1996; Currie, Nixon, and Cole 1996; Haas-Wilson 1996; Hansen 1980; Wetstein 1996).

The generosity of public assistance should also make abortion less attractive, but should do so by affecting the costs of childrearing instead. For some economically disadvantaged women, the availability of assistance such as health insurance, cash, a child care voucher, or job-protected leave time may not only defray the costs of parenthood, but may make it possible for them to consider the option in the first place. Generally the only welfare policy measure that has been considered in models of state abortion rates has been cash benefit levels under the Aid to Families with Dependent Children (AFDC) program. This research has produced mixed findings, with one study

finding that abortion rates and ratios were lower in states with higher AFDC benefit levels (Gohmann and Ohsfeldt 1993), others finding no relationship (Blank, George, and London 1996; Meier et al. 1996), and another finding that while birth rates increased with AFDC benefits, abortion rates were unaffected (Matthews, Ribar, and Wilhelm 1997). Chapter one reviewed additional literature outside the 50-state context, suggesting that a broader range of social policy could be related to reductions in abortion rates.

This chapter tests the hypothesis that more expansive state social welfare policies are associated with a reduction in abortion rates. I do not go so far, however, as to expect that the estimated impact of welfare generosity will exceed that of abortion access. Welfare assistance in the American states, after all, has a relatively limited scope and does not offer a comfortable living for those who receive it. Abortion policy may also be more immediately germane and salient to the millions of the individual decisions contributing to state abortion rates.

3.2 Data and Methods

I employ data from the 48 continental states[7] for the years 1988-2000. This time frame was chosen to capture several major changes in social welfare and abortion policy. States increasingly adopted family leave laws during the late 1980s and early 1990s, and the remaining states updated their laws upon passage of the federal Family and Medical Leave Act (FMLA) of 1993 (Waldfogel 1999). Also during this timeframe, states expanded Medicaid eligibility for pregnant women and infants (Joyce and Kaestner 1996). Congress created joint federal-state child care programs in 1990 and 1996, while states increasingly invested resources in their own child care initiatives (Committee on

[7] I exclude Alaska and Hawaii because my cost-of-living deflator was not available for them.

Family and Work Policies 2003). Policy change with respect to cash welfare, on the other hand, was better characterized by contraction than expansion. State experimentation with family caps, work requirements, and other get-tough reforms during the early to mid-1990s paved the way for the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. This law tightened welfare eligibility and granted states latitude to enact further restrictions (Lieberman and Shaw 2000; Soss et al. 2001).

In addition to serving as important arenas for family policymaking (Committee on Family and Work Policies 2003; Gornick and Meyers 2003), states constitute the major battlegrounds for abortion policy. States decide whether or not they will pay for poor women's abortions with their Medicaid funds, and they are the chief regulators of abortion providers. States' workload on abortion policy has increased substantially since the Supreme Court's *Webster* decision affirmed in 1989 their rights to legislate in this area (Goggin and Wlezien 1993).[8] As a result, substantial interstate variation exists in abortion access (NARAL Pro-Choice America Foundation 2005).

The dependent variable for this analysis is the *abortion rate*, or abortions per 1,000 women of reproductive age (age 15-44).[9] Nationally, this figured declined by 22 percent over my study period (Finer and Henshaw 2003), from 27.3 to 21.3. The measure begins with the number of abortions by state, collected by the Alan Guttmacher Institute

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[8] This is not to say that the national government does not play a role in abortion policymaking. The Partial-Birth Abortion Ban Act and the Unborn Victims of Violence Act are two notable examples of recent national abortion legislation. The performance of abortions at military facilities and for federal prisoners and the use of federal Medicaid dollars for abortions are also perennial subjects for Congressional debate that are usually settled in favor of the pro-life side. Because there has been little variation in national abortion policy during the study period but considerable change at the state level, however, states are the more appropriate unit of analysis for this study.

[9] Abortions are counted by state of occurrence since consistent data on abortions by state of residence are not available for the entire time period.

(AGI) in its surveys of all known abortion providers. Because these data were not collected for 1989, 1990, 1993, 1994, 1997, and 1998, I calculate state abortion rates for these years using a method similar to the Meier and McFarlane procedure (Meier et al. 1996; Meier and McFarlane 1994). I estimate each state's number of abortions by starting with the last available year of AGI data and applying the rates of change in each state's number of abortions for the next two years as observed in annual data collected by the Centers for Disease Control and Prevention (CDC). The CDC data are believed to be less complete than the AGI data (Jones and Forrest 1992), but like Meier and McFarlane, I assume that this bias is consistent across years. I divide abortion totals for all years by Census estimates of the number of reproductive age women (in 1000s) for each state. To check the sensitivity of my findings to another measure of abortion levels, I also run all models using the *abortion ratio*, abortions per 1,000 live births.

Family leave policies fall into three categories: no job-protected maternity leave law, a leave law equivalent to the FMLA, and a law more expansive than the FMLA. Beginning in 1993, all state laws had to be at least comparable to the FMLA. This mandated that private businesses of more than 50 employees offer 12 weeks each year of unpaid parental leave for birth, adoption, or other responsibilities, and guarantee a parent's job upon return. Ways in which states have exceeded FMLA include covering workers in smaller firms, offering longer leaves, and providing or requiring paid leave (National Partnership for Women and Families 2002).

Three policies represent the health care and cash assistance components of welfare policy. I measure access to maternal and child health care with the annual income ceiling (in 1000s) up to which pregnant women and infants qualify for Medicaid. Cash

welfare generosity is just each state's typical monthly cash benefit for a family of three (in 100s). Considerable interstate variation exists in the cost of living, however, which accounts for much of the nominal variation in welfare benefits (Albritton 1989; Schram, Nitz, and Krueger 1998). I thus adjust welfare benefits and Medicaid eligibility for variation in the cost of living across states and over time using the 2004 version of the Berry, Fording, and Hanson index (Berry, Fording, and Hanson 2000).[10] A third measure represents new restrictions on cash welfare assistance during the 1990s. This is a state's implementation of a "family cap," a policy that barred from welfare receipt all children born to unmarried welfare recipients.[11] Since this is the less generous policy option, I expect that this law will be positively related to the abortion rate.

No consistent, time-series state-level indicator of child care policy (such as subsidy eligibility or amounts, state funding, or child care tax credits) appears to have been collected and available for public use. Because child care is a theoretically important capacity-building tool with respect to women's decisions about whether to continue a pregnancy, I attempt to incorporate it nonetheless with a broader measure over a shorter time frame. Beginning in 1993, *Working Mother* magazine published an annual study of child care in the states. The study features a panel of experts' ranking of the 10 Best States for Child Care and also recognizes states outside the 10 best for progress and innovation. Criteria for the rankings include quantity of child care supply, maximum adult-to-child ratio, playground safety, frequency of inspections, teacher training requirements, thresholds for regulating family day care, child care funding, subsidies, and

[10] These data are available from ICPSR.

[11] The previous practice had been to increase a family's cash grant when another child joined the family. Beginning with New Jersey in 1992, the first family caps were implemented under a federal waiver. The 1996 PRWORA made the family cap an official policy option for states.

tax credits, political commitment to child care, and other issues relating to availability, safety, and affordability. The variation in this measure is not great; only 12 states were named among the top 10 during the study period.

Though not an established measure in academic research, *Working Mother's* measure has some practical advantages. It captures issues that are of concern to mothers of all income strata and thus in theory relates to the abortion decisions of the nonpoor, working female population. Additionally, the average mother may be more aware of her state's general position on child care than she is of specific regulations or subsidy amounts.

Table 3.1 lists the states with the most expansive family leave, child care, Medicaid, and cash assistance policies, as well as those states adopting a family cap. Three pieces of data form my measure of state policy on abortion access. I include two of the most common state laws affecting abortion access: parental consent or notification requirements for minors' abortions and bans on the use of state Medicaid money for abortions. These are by no means the only state policies affecting abortion access, but they are the most commonly studied. States are credited with these policies only if the law was enforced in a given year, to help cope with the possibility that states whose populations are less supportive of abortion are more likely to pass these laws (Gerber 1996; Wetstein 1996). Previous research shows that abortion policy predicts abortion supply (Hansen 1980; Wetstein 1996), so I include in my access measure the number of abortion providers per 100,000 population. This may help capture the effects of a fuller

range of abortion policy measures. Since this figure, as expected, is closely correlated with the two abortion policy measures, I form a single factor from the three.[12]

Table 3.1. The American States on Social Policy

Family Leave	Child Care	Welfare Benefits and Medicaid	Family Cap
State law more generous than FMLA at least one year 1988-2000: California Connecticut ~~Hawaii~~ Iowa Louisiana Maine Massachusetts Minnesota Montana New Hampshire Oregon Vermont Washington *Adopted pre-1993 law comparable to FMLA:* New Jersey Rhode Island Tennessee Wisconsin	*Ranked on* Working Mother's *10 Best List at least one year 1993-2000:* California Colorado Connecticut ~~Hawaii~~ Illinois Maryland Massachusetts Minnesota Rhode Island Vermont Washington Wisconsin *Recognized for improvements in child care at least one year 1993-2000:* Arizona Arkansas Delaware Florida Georgia Indiana Missouri North Carolina Oklahoma Oregon	*10 Highest Average Welfare Benefits, 1988-2000:* California Vermont Wisconsin Washington Minnesota New York Massachusetts Oregon Rhode Island Michigan *10 Highest Medicaid Eligibility Thresholds, 1988-2000:* Tennessee Minnesota Mississippi Kentucky South Carolina Texas California North Carolina Florida Rhode Island	*Enforced family cap at least one year 1988-2000:* Arizona Arkansas California Connecticut Delaware Florida Georgia Idaho Illinois Indiana Maryland Massachusetts Mississippi Nebraska New Jersey North Carolina North Dakota Oklahoma South Carolina Tennessee Virginia Wisconsin Wyoming

Welfare benefits are average monthly benefit for a family of three and Medicaid eligibility is the income level at which pregnant women and infants are eligible for Medicaid. Welfare benefits and Medicaid eligibility thresholds are adjusted using the 2004 edition of Berry, Fording, and Hanson's state cost-of-living deflator. Rankings for welfare and Medicaid do not include Alaska and Hawaii, since cost of living deflator was not available.

[12] These measures load on a single principal components factor (eigenvalue=1.77).

Additional controls I include are the percentage of state's population living in a metropolitan area, the black share of population and a state's socioeconomic status. I represent the latter with a factor score of per capita income, the percentage of the population with a high school diploma, the unemployment rate, and the female labor force participation rate. Because of nonlinearity in the relationship between socioeconomic status and abortion rates, I also include a squared term.[13] To help adjust for regional patterns in policy diffusion and the possibility that women may be traveling to neighboring states for abortions, I include dummy variables for eight of the nine Census regions in some models. Sources and additional coding information for all variables are noted in the appendix.

To cope with the heteroskedasticity, contemporaneous correlation, temporal dependence, and other issues inherent to much panel data, I estimate my models using cross-section time-series Prais-Winsten regression with panel-corrected standard errors, assuming first-order autocorrelation (Beck and Katz 1995). For each analysis, I present two sets of models: a "static" model that predicts each state's abortion rate in a given year, and a "change" model that controls for the previous year's abortion rate. Thus coefficients in the latter model represent predictors' estimated effects on the yearly change in abortion rates.

[13] I initially also included Hispanic share of population, the marriage rate, percent Catholic, and percent evangelical as controls in the model. The marriage rate variable was problematic because Nevada is an extreme outlier in all years. The other three variables were not statistically significant and their removal had little effect on remaining coefficients. Others have shown (O'Connor and Berkman 1995; Wetstein 1996) that religion variables are related to abortion policy but not to abortion rates.

3.3 Results

Overall, social welfare generosity does appear to be associated with abortion rates, but the direction and magnitude of the relationship varies by program area. Table 3.2 reports estimates for the 1988-2000 time frame while Table 3.3 reports estimates for the 1993-2000 time frame, in which child care variables are included. In each table, columns 1 and 3 represent the "static" model, while columns 2 and 4 display estimates from the "change" model.

Nearly all models suggest that improved access to maternal and child health care predicts lower, faster falling abortion rates. The contribution of Medicaid eligibility policy to the abortion rate is modest, but is marginally significant ($p<.10$, two-tailed) over 1988-2000 when controlling for regional effects. This finding holds in the static model for the 1993-2000 time frame, though the coefficient crosses to the positive side of zero and is not significant in the change model. This makes sense, considering that states instituted most eligibility changes earlier in the study period. Using column 4 of Table 3.2, a $1,000 increase in the cost-of-living-adjusted Medicaid eligibility threshold is associated with a reduction of 0.022 in the abortion rate relative to the previous year. To give a sense of the potential magnitude of this coefficient, nearly $15,000 separated the least and most generous states in 1988 from the least and most generous states in 2000, while $24,000 separated the most and least generous states in 2000.

The passage of family leave laws also appears to have contributed to reductions in abortion rates. Over 1988-2000, this coefficient is consistently negative and is significant in three of the four specifications. Columns 2 and 4 suggest that adoption of a FMLA-style family leave law, or the expansion of a FMLA-style law, predicts a reduction of 0.2

Table 3.2. The Impact of Policy on the Abortion Rate, 1988-2000

	Column 1	Column 2	Column 3	Column 4
Welfare Benefits	1.248***	0.070	1.257***	0.069
	(0.239)	(0.082)	(0.254)	(0.077)
Medicaid Eligibility	-0.038	-0.018	-0.043*	-0.022*
	(0.024)	(0.012)	(0.025)	(0.012)
Family Cap	-0.034	0.192	-0.070	0.216
	(0.474)	(0.258)	(0.470)	(0.266)
Family Leave	-0.601*	-0.220**	-0.660*	-0.187
	(0.342)	(0.110)	(0.362)	(0.132)
Abortion Access Limits	-2.441***	-0.363**	-2.124***	-0.400**
	(0.438)	(0.147)	(0.478)	(0.192)
Percent Metro	0.258***	0.017**	0.253***	0.018**
	(0.013)	(0.007)	(0.015)	(0.008)
Percent Black	0.103**	0.019*	0.080	0.012
	(0.041)	(0.011)	(0.049)	(0.012)
SES	-0.494	0.001	-0.483	-0.016
	(0.329)	(0.108)	(0.342)	(0.116)
SES Squared	-0.201*	0.002	-0.222*	-0.011
	(0.121)	(0.045)	(0.124)	(0.049)
Abortion Rate (t-1)	--	0.927***	--	0.925***
		(0.027)		(0.027)
Constant	-3.160**	-0.022	-1.004	0.198
	(1.298)	(0.418)	(1.855)	(0.484)
Regional Dummies	--	--	Yes	Yes
R2	0.657	0.961	0.670	0.962
N	624	624	624	624

Dependent variable is abortions per 1,000 women aged 15-44. Panel corrected standard errors in parentheses. All models corrected for first-order autocorrelation.
* p<0.10, ** p<0.05, *** p<0.01, two-tailed.

Table 3.3. The Impact of Policy on the Abortion Rate, 1993-2000

	Column 1	Column 2	Column 3	Column 4
Welfare Benefits	1.723***	0.096	1.496***	0.069
	(0.348)	(0.139)	(0.374)	(0.128)
Medicaid Eligibility	-0.034	0.009	-0.038*	0.001
	(0.023)	(0.012)	(0.023)	(0.012)
Family Cap	0.141	0.263	0.126	0.303
	(0.360)	(0.245)	(0.359)	(0.268)
Family Leave	-0.135	-0.011	-0.621	0.126
	(0.721)	(0.252)	(1.056)	(0.399)
Best Child Care	-2.372**	-0.824**	-1.906*	-0.700*
	(1.046)	(0.344)	1.095	(0.369)
Improved Child Care	0.860	-0.091	0.820	-0.135
	(0.637)	(0.474)	(0.591)	(0.507)
Abortion Access Limits	-2.630***	-0.429**	-2.354***	-0.513**
	(0.528)	(0.170)	(0.639)	(0.191)
Percent Metro	0.263***	0.023***	0.261***	0.025***
	(0.013)	(0.008)	(0.016)	(0.008)
Percent Black	0.205***	0.020	0.226***	0.007
	(0.049)	(0.020)	(0.057)	(0.022)
SES	-0.502	0.120	-0.620*	0.067
	(0.329)	(0.115)	(0.341)	(0.130)
SES Squared	-0.065	0.017	-0.080	-0.025
	(0.123)	(0.049)	(0.132)	(0.050)
Abortion Rate (t-1)	--	0.914***	--	0.913***
		(0.031)		(0.031)
Constant	-7.733***	-1.207	-6.713***	-0.672
	(1.642)	(0.754)	(2.015)	(0.566)
Regional Dummies	--	--	Yes	Yes
R2	0.723	0.965	0.730	0.967
N	384	384	384	384

Dependent variable is abortions per 1,000 women aged 15-44. Panel corrected standard errors in parentheses. All models corrected for first-order autocorrelation.
* p<0.10, ** p<0.05, *** p<0.01, two-tailed.

in the abortion rate on top of the previous trend. The coefficient does not achieve significance over the 1993-2000 time frame and actually turns positive in one model, but this also makes sense in light of the timing of family leave legislation. Only one state changed its leave law after 1993.

Perhaps the most dramatic inverse relationship with abortion rates that can be credited to state social policy involves the availability, affordability, and quality of child care. All else equal, abortion rates were significantly lower and underwent significantly

larger reductions in the states ranked among the 10 Best for child care. Models in columns 2 and 4 estimate that in a given year, such a designation is associated with a reduction of nearly one abortion per 1,000 women of reproductive age from the previous year's rate. Among the other 40 states, recognized improvement in child care policy and supply is statistically unrelated to abortion rates. It remains possible that a link could be uncovered if the models allowed for some lag time over which would-be parents might gain awareness of changes in their state's child care offerings, or that the 10 Best designation could really be capturing some factor specific to those states, since the rankings do not shift much.

In contrast to the above three types of in-kind assistance available to the working class or to parents generally, cash assistance targeted at the poorest of the poor appeared associated with the abortion rate in the opposite of the hypothesized direction. Increases in the generosity of cash welfare benefits are associated with significantly higher abortion rates in each period, with and without controlling for regional patterns. Each $100 increase in monthly cash benefits predicted an increase of about 1.3 abortions per 1,000 women of reproductive age. Again to provide scale, about $500 separated cost-of-living-adjusted benefits in the most and least generous states in 2000. The least generous state actually paid just slightly less in 2000 than the least generous state in 1988, while the most generous state in 2000 paid nearly $300 dollars less in 2000 than in 1988, pointing to a decline in the real value of cash welfare assistance. The generosity of welfare benefits does not appear to contribute to changes in abortion rates, though its estimated coefficient is always positive.

Implementation of a family cap has no statistically discernible effect on abortion rates, though the coefficient is positive as hypothesized in every model save for the 1988-2000 static models. Though the prospect of bearing another child without an increase in financial assistance may indeed still increase abortions among women on welfare, any effect on the statewide abortion rate is not large enough to register as statistically significant.

Limits on abortion access via state policy and abortion provider supply strongly and consistently predict lower abortion rates as well as reductions in abortion rates. An increase of one standard deviation in limitations on abortion access is associated with a reduction in the abortion rate of about 0.4, on top of the already lower abortion rates predicted for such states.[14] Another access-related measure, the state's degree of urbanization, consistently predicts significantly higher abortion rates and significant increases in abortion rates.

The hypothesis that social welfare generosity should reduce abortion rates thus receives a mixed judgment. The above results offer evidence that expansiveness in child care, family leave, and health care policy may have helped individual states lower their abortion rates and may have contributed to the downward trend in this measure. On the other hand, the unexpected positive coefficient on welfare benefits roughly cancels out this progress. When measuring capacity-building tools with the welfare policy of the contemporary American states, the "authority tool" (Schneider and Ingram 1990) of abortion access legislation appears more closely linked to abortion levels.

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[14] The abortion access factor score ranges from –3.54 to 1.39 with a standard deviation of 1. Higher values indicate more limits.

To check findings' sensitivity to measurement of abortion levels, I repeated the above analysis using the abortion ratio as the dependent variable. This statistic is the ratio of abortions to live births, a figure that fell by 19 percent over the study period, from 401 in 1988 to 324 in 2000. Though less conventional in the study of abortion usage, this measure perhaps better represents the balance of decisions between abortion and childbirth. [15] On the one hand, one might expect that negative relationships between social welfare policy and abortion should be stronger by this measure, if indeed social welfare policy improves poor women's capacity to choose childbirth. On the other hand, social welfare policy—especially those programs aimed at helping mothers retain employment—could prevent an abortion in the short run while holding down births over the long run, by increasing women's attachment to the labor force (Presser and Baldwin 1980) and perhaps, through Medicaid expansions, also increasing access to contraceptives. Thus it is unclear whether we should expect stronger results.

Tables 3.4 and 3.5 report the results of this analysis. The same general pattern of results obtains. Coefficient signs are similar, though in fewer instances do the social policy measures meet standard tests of statistical significance. Expanded access to maternal and child health care strongly and significantly predicts lower abortion-to-birth ratios in all static models, though it does not predict changes in the abortion ratio. Reductions in the abortion ratio associated with family leave laws are not significant, and this coefficient does turn positive though insignificant in three of four models in the shortened time frame. Ranking among the 10 Best states for child care is associated with a significant reduction in the abortion ratio when regional patterns are not controlled, and

[15] Of course, without detailed individual-level data we cannot discern how much of any decrease in the abortion ratio is actually women's substitution of childbirth for abortion.

Table 3.4. The Impact of Policy on the Abortion Ratio, 1988-2000

	Column 1	Column 2	Column 3	Column 4
Welfare Benefits	21.375***	1.142	20.275***	0.604
	(3.307)	(1.146)	(3.519)	(1.154)
Medicaid Eligibility	-0.775***	-0.083	-0.922***	-0.124
	(0.289)	(0.152)	(0.286)	(0.147)
Family Cap	3.054	2.890	1.091	2.862
	(6.431)	(3.423)	(6.256)	(3.574)
Family Leave	-2.417	-1.788	-5.017	-1.545
	(4.301)	1.570	(4.383)	(1.815)
Abortion Access	-36.295***	-5.036**	-35.365***	-6.005*
	(6.579)	(2.311)	(7.199)	(3.100)
Percent Metro	3.677***	0.243***	3.458***	0.273***
	(0.214)	(0.093)	(0.222)	(0.102)
Percent Black	1.881***	0.196	1.364**	0.128
	(0.654)	(0.166)	(0.656)	(0.185)
SES	-4.375	-0.922	-3.614	-1.565
	(4.233)	(1.381)	(4.017)	(1.455)
SES Squared	-1.883	-0.198	-3.237*	-0.496
	(1.578)	(0.615)	(1.670)	(0.691)
Abortion Ratio (t-1)	--	0.928***	--	0.920***
		(0.026)		(0.029)
Constant	-47.433**	-4.365	19.328	2.268
	(23.949)	(6.508)	(25.694)	(7.748)
Regional Dummies	--	--	Yes	Yes
R2	0.648	0.961	0.694	0.962
N	624	624	624	624

Dependent variable is abortions per 1,000 live births. Panel corrected standard errors in parentheses. All models corrected for first-order autocorrelation. * p<0.10, ** p<0.05, *** p<0.01, two-tailed.

Table 3.5 The Impact of Policy on the Abortion Ratio, 1993-2000

	Column 1	Column 2	Column 3	Column 4
Welfare Benefits	30.372***	3.112	25.446***	2.846
	(5.505)	(1.990)	(5.804)	(2.021)
Medicaid Eligibility	-0.665**	0.038	-0.834***	-0.152
	(0.286)	(0.202)	(0.271)	(0.200)
Family Cap	4.578	3.403	2.551	3.802
	(5.915)	(3.815)	(5.949)	(4.245)
Family Leave	7.345	0.217	-4.384	1.559
	(11.386)	(4.060)	(15.316)	(6.376)
Best Child Care	-26.823	-10.455*	-24.420	-8.944
	(17.024)	(5.346)	(17.194)	(6.152)
Improved Child Care	14.467	-1.104	13.348	-1.808
	(10.043)	(7.027)	(9.055)	7.554
Abortion Access Limits	-41.456***	-5.735**	-39.040***	-7.815**
	(8.006)	(2.812)	(9.255)	(3.107)
Percent Metro	3.590***	0.320***	3.489***	0.405***
	(0.230)	(0.099)	(0.259)	(0.115)
Percent Black	3.913***	0.341	3.238***	0.128
	(0.792)	(0.318)	(0.864)	(0.340)
SES	-3.907	-0.163	-4.102	-1.016
	(4.627)	(1.678)	(4.982)	(1.987)
SES Squared	-1.469	0.063	-2.811	-0.827
	(1.813)	(0.799)	(2.043)	(0.847)
Abortion Rate (t-1)	--	0.925***	--	0.912***
		(0.029)		(0.032)
Constant	-110.647***	-22.446**	-49.098*	-10.917
	(29.937)	(11.223)	(29.242)	(10.460)
Regional dummies	--	--	Yes	Yes
R2	0.717	0.962	0.739	0.962
N	384	384	384	384

Dependent variable is abortions per 1,000 live births. Panel corrected standard errors in parentheses. All models corrected for first-order autocorrelation. * p<0.10, ** p<0.05, *** p<0.01, two-tailed.

the coefficient remains negative in all other specifications. Cash welfare generosity remains linked to higher abortion levels, though it also remains unrelated to changes in these levels. The family cap always carries a positive but insignificant coefficient. Limitations on abortion access remain powerful predictors of lower, faster-falling abortion levels.

3.4 Discussion

This study suggests that capacity building policy tools have a modest though somewhat inconsistent effect on the usage of abortion by a state's population. Over 1993-2000, abortion rates fell faster in states with the highest child care availability, quality, assistance, and commitment. Over 1988-2000, abortion rates also fell faster in states where more pregnant women were income-eligible for health care through Medicaid and where family leave laws were in effect or were more expansive.

When trying to estimate the overall impact of social welfare policy on abortion rates, however, we are confounded by the puzzling finding that predicted abortion rates are higher in states where cash welfare payments are more generous, even after controlling for other determinants of abortion usage. In hindsight perhaps this is not so surprising. The average monthly welfare payment for a family of three—$408 in 2000, adjusted for cost of living— hardly sounds "generous," and public assistance alone is often insufficient for meeting a family's basic expenses (Edin and Lein 1997). The relatively small cash differences that exist across states and between years may not be enough to appreciably improve the economic "capacity" of potentially welfare-eligible women to continue a pregnancy and raise a child. Meanwhile, this marginal difference in payments may be sufficient to help poor women procure abortions, particularly in states were Medicaid does not pay for abortions. That cash welfare is fungible separates it from the three other forms of assistance considered in this paper. Health care for pregnant women, child care, and leave time are in-kind assistance designed for women who choose childbirth; it is more of a stretch to imagine how greater welfare generosity in these areas could increase abortion rates.

Considering the small size and scope of the American welfare states relative to those of other developed countries, perhaps it is remarkable that effects of these policies registered at all on aggregate abortion rates. Should an individual state or the national government adopt more European-style social policies—which are more universal and include such measures as extended paid parental leave and guaranteed, publicly funded child care (Committee on Family and Work Policies 2003)—the impact on abortion rates could be substantial. The political climate in the United States, however, is generally more suggestive of social policy retrenchment than expansion (Hacker 2004). The finding that the generosity of some social welfare policies does appear linked to reductions in abortion rates thus cautions that proposed further cuts in public programs such as Medicaid (Weisman 2005) may not be without consequence for the childbearing decisions of low-income women.

This study has its limitations, and chief among them is its use of data aggregated to the state level. Even if we observe that welfare generosity is associated with lower abortion rates, we cannot know that the policy itself is affecting its target population in the manner hypothesized. Even with stronger and more significant findings than those reported here, a positive relationship between a family cap, for example, and a state's abortion rate means little more than just that: all else in the model being equal, states with family caps have higher abortion rates. One cannot validly infer that *welfare recipients* in states with family caps have higher abortion rates, much less that an individual pregnant welfare mother, aware of her state's new family cap, decided to abort a child she would have otherwise raised. Likewise, we cannot infer that decreases in the abortion ratio in the child care states took place among working or career-oriented women. Reliable

abortion statistics for such populations do not appear to exist. In the next two chapters, however, I do draw on individual-level data that enable me to assess the extent to which the abortion decisions of specific target populations such as welfare recipients appear to be affected by social policy.

We still have much to learn about why the estimated effects of welfare policies on abortion rates differ by policy type. Medicaid, child care policy, and family leave policy all reach a larger, somewhat better-off segment of state populations than cash welfare does. This is by virtue of higher income eligibility standards in the case of Medicaid and child care vouchers, and the more universal coverage of policies pertaining to child care regulation and job-protected leave for employees of large firms. Do policies in these areas appear more effective at reducing abortion rates over time because they are available to a larger number of women, or because they are available to women who might be more predisposed toward childbirth? Could it be that by virtue of being steps closer to universality, these programs attract more potential clients, enjoy greater political support, and are more effectively implemented (Skocpol 2000)? From this analysis, state policy related to child care cost, quality, and availability appears particularly promising for its potential to reduce abortions, but the broadness of this paper's measure precludes a judgment on which components of being a "best state for child care" are most relevant for childbearing decisions. Recall that this measure incorporates state actions to defray the cost of child care, as well as other measures such as the stringency of health, safety, and training requirements (which may increase parents' comfort level with child care) and state politicians' commitment to child care (which may increase parents' awareness of their child care options).

Simple crosstabulations from a published study of abortion patients suggest that if welfare policies broadly defined are reducing abortion rates, they are doing so by affecting the behavior of women other than the poorest of the poor. Relative to 1994, this study found that abortion rates decreased for higher income, more educated women while increasing among less advantaged women (Jones, Darroch, and Henshaw 2002). Such statistics represent only two snapshots and do not account for intervening variables. They are nonetheless roughly consistent with the findings of this study, that policies aimed at women who are not poor (family leave and some components of child care policy) or available to the working class in addition to the poor (Medicaid and other components of child care policy) were negatively associated with the abortion levels, while a service available to poor women alone—cash welfare—was positively related to the abortion levels.

To what extent falling U.S. abortion levels been driven by the decisions of higher-SES women is a question for more detailed data than these. Any research showing that the abortion rates of the poorest women are less sensitive to welfare policy does not necessarily doom the theory that capacity-building policy should reduce abortion, so long as the behavior of other welfare programs' beneficiaries does appear to be affected. Studied in the American context alone, a relative lack of sensitivity in poor women's childbearing behavior may simply suggest that available assistance is too paltry to do what theory says it should—build the economic capacity of individuals to choose parenthood when they wish to do so.

This study therefore is a more appropriate beginning than a conclusion to research on the empirical relationship between welfare generosity and abortion. Its results suggest

that the expansiveness of health care, child care, and family leave policy across states and time contributed modestly to lower abortion rates. The effects of welfare policies, especially when the contrary finding for cash welfare is considered, do not supplant or surpass the estimated relationship of abortion access policy on citizen behavior, but this was not expected to be the case in the contemporary American states. Both policy tools contribute independently to abortion rates. These findings then will not likely persuade aware individuals and groups who politically value abortion reductions to become Democratic supporters, if they do not have strong preferences regarding the means to this end. Such conversion would increase their risk of trading off the more consistent effects of abortion access policy.

Further speculation on how a modification or reframing of either party's position on social welfare or abortion would alter mass political behavior and the partisan balance of power must wait for chapter seven. What this chapter does indicate is an empirical, behavioral linkage between these two dimensions—that states' social welfare policy helps explain their populations' practice of a particularly politicized behavior. Rhetoric that liberal social welfare can bear "pro-life" fruits does have some basis in reality, but we do not know if the same is true for these common-grounders' political optimism.

Chapter 4: Are Social Welfare Policies 'Pro-Life'?: An Individual-Level Analysis of Low-Income Women

Chapter three offered preliminary evidence of a role for social welfare policy in reducing abortions. Its use of state-level abortion rates, however, precluded judgment over whether the observed reductions in abortions had occurred among women served by the relevant programs. Further, the finding that policies directed at wider, relatively better-off groups of women were negatively linked to abortion rates while the program serving the poorest of the poor, cash welfare, was positively linked to abortion rates calls for additional exploration. It could be that poor women's abortion decisions are not as sensitive to economic resources as we might think, or that American welfare programs are not generous enough to truly function as capacity-building tools, or that these relationships are spurious.

In this chapter, I analyze data from a sample of urban, predominantly low-income and single mothers, in order to test for relationships between economic hardship, welfare program participation, and pregnancy resolution. This chapter tests the hypothesis that low-income women's likelihood of choosing abortion will decrease as their access to and participation in social welfare programs increases. Secondarily, it notes how any reduction in abortion associated with social welfare programs compares to that achieved by alternative policy tools: the private safety net and limitations on abortion access.

Findings do not support the central hypothesis. Welfare program participation and state welfare generosity are positively associated with the likelihood of choosing abortion. The existence and magnitude of this relationship, however, is mediated by the rules of state welfare bureaucracies and also varies by women's race and marital status.

Limitations on abortion access appear to reduce abortions, while the nongovernmental safety net does not affect abortion decisions.

4.1 Data and Methods

Data come from the restricted version of the Fragile Families and Child Wellbeing study conducted by Princeton University's Center for Research on Child Wellbeing and the Columbia University School of Social Work's Social Indicators Survey Center. Beginning in the late 1990s, researchers interviewed a sample of 4,898 mothers upon the birth of a child (the "focal child"). Most were re-interviewed when this child was 12-18 months old and again when the child was three. Mothers were questioned extensively about their receipt of public and private assistance and about economic hardships in their lives. They were also asked whether they had been pregnant since the birth of the focal child and about the outcome of those pregnancies. I draw most of my data from the one-year follow-up study, pulling data from the first and third wave files when appropriate.

Since the restricted version of the data includes the mother's city of residence, I am able to link these data with social welfare and abortion policies in each mother's state (see appendix).

I confine my analysis to women who became pregnant between the birth of the focal child and their second interview. Following some minor coding decisions that are enumerated in the appendix, I am left with a sample of 850 women, 26 percent of whom had ended at least one pregnancy in abortion. Table 4.1 contains demographic summary statistics.

Table 4.1 Fragile Families Summary Statistics

	Mean	Standard Dev.	Observations
Age	24.7	5.4	846
Number of biological children	2.3	1.4	850
Married	0.253	0.434	850
Black	0.559	0.497	841
Less than high school diploma	0.381	0.486	848
Some college	0.265	0.442	848
College graduate	0.064	0.244	848
Weekly church attendee	0.261	0.440	849
Employed or in school	0.580	0.494	849
Economic hardship in last year	0.536	0.499	850
Cash welfare in last year	0.348	0.477	850
Food stamps in last year	0.475	0.500	848
Child care subsidy (current recipient)	0.097	0.296	849
WIC in last year	0.785	0.411	848
Housing assistance (current recipient)	0.250	0.433	839
Medicaid/public health ins. (current recipient)	0.258	0.438	423
Earned Income Tax Credit (applied)	0.331	0.471	782
Chose abortion	0.258	0.438	850

Admittedly, these data do not represent the population of pregnant American women. Because the study's focus is on unmarried parents ("fragile families"), the sample was drawn from hospitals where large numbers of single mothers delivered, located in 20 American cities (listed in the appendix) of 200,000 or more residents (Bendheim-Thoman Center for Research on Child Wellbeing 2003; 2004). The study thus disproportionately captures unmarried women, women of color, urban women and women of low socioeconomic status. Further, since they entered the study through childbirth, all respondents had at least one child. These women may face a less dramatic life change and different opportunity costs compared to those who have not experienced parenthood, and a prior birth may indicate a preference for childbearing.

Though this paper's findings generalize only to urban, relatively low-SES mothers, on a topic where data are scarce the Fragile Families sampling design actually improves suitability of these data for studying the role of social welfare programs in

women's reproductive decisions. Because most people are not eligible for the welfare programs under consideration without being parents, results from a correlational study that included childless women would be biased. The sample's low socioeconomic status also improves prospects for disentangling the effect of welfare programs from the effect of a low income, since most respondents have some degree of economic need. Nearly 54 percent of women in the sample report at least one instance of severe economic hardship (defined in the appendix) in the previous year, such as going hungry, falling short of money to pay the rent or mortgage, having electricity cut off, or forgoing needed medical treatment. While half of the sample reports an annual income of over $60,000, this figure is deceptive. Respondents were asked the total pretax income of all people living with them from all sources, not just wages. Adults per household averaged 2.2 and ranged up to 10, and this was positively correlated with income.

Women with previous births are also not as small a subset of abortion patients as some may believe. Such women made up over 60 percent of abortion patients in 2000. Women with one previous live birth terminated pregnancies at a considerably higher rate (32 abortions per 1000 women) than women with no previous live births (19 per 1000); abortion rates among women with two or more previous live births were comparable to those with none (18 abortions per 1000 women) (Jones, Darroch, and Henshaw 2002).

The dependent variable for this analysis is a dummy variable equaling 1 if the respondent reported resolving a pregnancy in abortion. An important issue involves the quality of abortion reporting, since researchers believe most survey data on this sensitive topic is beleaguered by substantial underreporting (Jagannathan 2001; Jones and Forrest 1992). Some national data suggest that reporting in the Fragile Families study may be

fairly complete. In 2000, nearly a quarter of pregnancies (excluding miscarriages, thus inflating the figure) ended in abortion (Finer and Henshaw 2003); of those pregnancies that had been completed by the one-year interview, nearly half ended in abortion. These two statistics are not directly comparable, though, so a concern about underreporting cannot be entirely dismissed. Some women in the study would not have had enough time to recover their fertility and bear another child. Some characteristics of the women oversampled—urban, unmarried, minority, and low-SES—predict higher abortion rates than the population's, while their 2.3 children predict lower rates (Finer and Henshaw 2003).

I employ three measures of respondents' access to and participation in social welfare programs.[16] The first is an index of the number of welfare programs from which a respondent had received assistance in the previous 12 months, coded to range from 0-1. I consider cash welfare, food stamps, public health insurance, child care subsidies, the Earned Income Tax Credit, the Women, Infants, and Children Nutrition Program (WIC), and public housing and rental assistance.[17] I also consider the generosity of a woman's potential safety net, measured by per capita spending on public welfare in her state. These figures are adjusted using the 2004 version of Berry, Fording, and Hanson's state cost of living index (Berry, Fording, and Hanson 2000). On a subsample of respondents who were or believed themselves to be eligible for public assistance, my third measure is an indicator of whether a woman failed to receive assistance. This group includes women who did not apply for welfare or food stamps, or whose applications were denied. It also

[16] A simple indicator of whether or not a respondent had received assistance did not vary enough to justify its use. Only 23 women had not participated in at least one of 7 programs considered.
[17] Initially I also included Supplemental Security Income and an "other assistance" category, but later dropped these because they did not scale well with the other measures.

includes respondents report they are eligible for but not currently receiving child care subsidies, and women whose cash welfare benefits have been reduced or eliminated because they did not fulfill program requirements. I hypothesize that all measures of welfare receipt and welfare generosity will be associated with a lower likelihood of abortion, and that this effect should show up most strongly when looking only at the poorest mothers.

Because conservative Republicans rhetorically place primary responsibility for the safety net with families, churches, and other private actors, and further argue that privately provided assistance is more effective than public assistance, I also include two measures of the nonpublic safety net. The first is a scale indicating the number of areas in which a respondent received help from family, friends, or other nongovernmental sources: money, child care (financial aid or relative care), and housing (lives rent-free with relatives, friends, or others). The second is another scale measuring the number of situations in which the respondents could "count on" someone to provide the following: loans of $200 or $1000, emergency child care, a place to live, or a co-signature for loans of $1000 or $5000. I expect that women with more private assistance at their disposal will also be less likely to choose abortion.

Abortion access is measured with the ratio of abortion providers to state population and with indicators of whether a state was enforcing each of three policies in 2000: a ban on the use of state Medicaid funds for abortions, a requirement for parental consent or notification prior to a minor's abortion, and a law mandating waiting periods and the provision of specific information to women seeking abortion. Because these four measures were highly correlated and theoretically related (Hansen 1980; Wetstein 1996),

I formed one abortion access factor. Women should be more likely to choose abortion when residing in states where it is more accessible.

Family planning advocates argue that improved access to contraception will reduce abortion. According to this hypothesis, women living in states that have provided better access to family planning should be less likely to choose abortion, as more of the pregnancies that do occur will be intended. While the federal government sets and funds most family planning policy, some notable state-level variation exists (Schwalberg et al. 2001). I thus form a scale of four state family planning policies on which there is substantial variation, as of January 2001: a mandate that all prescription drug plans cover contraceptives, whether states add their own funds to family planning programs, Medicaid coverage of emergency contraception, and Section 1115 waivers that expand Medicaid family planning eligibility beyond federal income guidelines.

Models also control for economic hardship,[18] age, marital status, education, race (black or nonblack), whether a respondent is employed or in school, domestic violence (abuse by the father of the focal child or current partner), and moral predisposition toward abortion. Since the survey does not include questions about abortion attitudes, I proxy this latter concept with an indicator of whether or not the respondent attends religious services at least once a week.[19] One model interacts welfare variables with race and marital status, as some previous research has revealed differences in how welfare participation and marriage status affect the reproductive behavior of black versus

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[18] Income lacks response options above the sample median. It has no predictive power even by itself, even when the relationship is not constrained to be linear.

[19] Church attendance powerfully predicted the abortion decision in a bivariate model, while an alternative measure based on respondents' agreement with traditional gender roles and the superiority of marriage to cohabitation was unrelated to the abortion decision. The survey's measure of religious affiliation is inadequate because one cannot distinguish between different types of Christians.

nonblack women (Joyce and Kaestner 1996; Moffitt 1997; Trent and Powell-Griner 1991). I also allow the effects of economic hardship and the nongovernmental safety net to vary by race. Models reported are logistic regression models.

4.2 Results

As expected, simple descriptive statistics indicate a fairly solid link between economic hardship and the likelihood of abortion. Table 4.2 shows the proportion of women choosing abortion, by their economic experiences over the previous 12 months. Significantly higher percentages of women who reported at least one of 12 economic hardships terminated their pregnancies—31 percent, as opposed to 20 percent of other women. A gap of similar magnitude exists between women whose welfare benefits were cut because of program noncompliance and women who received full benefits. The proportions choosing abortion among women with unreliable child care arrangements or who quit a job or schooling due to lack of child care were 18 and 15 percentage points greater than those of other employees and students.

On the other hand, the expected negative relationship does not appear between welfare program participation and the proportion of women turning to abortion (Table 4.2). While four programs show no significant differences, significantly higher ($p<.05$) proportions of women among cash welfare, WIC, and child care subsidy recipients ended a pregnancy in abortion. The case of child care subsidy recipients is most striking: 46 percent of subsidy recipients ended a pregnancy in abortion, compared to 24 percent of other employees and students.

Several considerations may explain these findings. First, program participation may be picking up the effect of economic hardship rather than public assistance. A

Table 4.2 Proportion of Women Choosing Abortion, By Economic Experience

Economic issue	Proportion Choosing Abortion
Inability to afford at least one basic need#	30.9**
Welfare benefits cut for program noncompliance	41.9*
Welfare benefits cut or assistance application denied	29.3
Quit job or school because of lack of child care	45.0**
Child care fell through multiple times in previous month	47.4**
No emergency child care	27.0
No health insurance	23.0
Welfare recipient	30.1**
Food stamps recipient	26.1
WIC recipient	27.8**
Medicaid recipient	26.6
Housing assistance recipient	29.1
Applied for Earned Income Tax Credit	30.9*
Child care subsidy recipient	46.0**
Possibly eligible but no benefits	29.3
Overall Sample	25.8

#See "economic hardship" in appendix for definition. **Significantly different at .05 from appropriate comparison group (i.e., other employed women, other welfare recipients) *p<.10

significant 38 percent of mothers who had been unable to afford at least one basic need were cash welfare clients, as opposed to 31 percent of those who did not report such severe need. Besides their low incomes, recipients of public assistance have other characteristics common among abortion patients: they are disproportionately black (Jones, Darroch, and Henshaw 2002; Schram 2003) and unmarried. Compared to all women, greater proportions of welfare recipients (Tolman and Raphael 2000) and abortion patients (Glander et al. 1998) suffer from domestic violence. Further, since state policy liberalism on one dimension highly correlates with policy liberalism on other dimensions (Erikson, Wright, and McIver 1993), states offering more generous welfare programs may also have more liberal abortion policies. By some measures, they do (Schroedel 2000), and this may create the appearance of a positive relationship between welfare generosity and abortion.

In practice, however, controlling for these concerns does not dramatically reduce the positive relationship between welfare program participation and the abortion decision. Table 4.3 reports results from logistic regression models. Columns 1-4 consider all mothers for whom data are available, while columns 5 and 6 consider roughly the lowest third of the sample's income distribution, women whose total household incomes from all sources fall under $30,000. Columns 3 and 6 analyze subsamples of these two groups, women who are eligible or believe they were eligible during the previous year for welfare, food stamps, or child care assistance.

Findings from the logistic regression models continue to contradict expectations of the theory that welfare enables childbearing. In columns 1 and 2, the number of social welfare programs from which a family receives assistance actually predicts a marginally significant increase in the odds that a pregnant woman would choose abortion, nearly doubling the odds for women who take part in all seven welfare programs as opposed to none. Holding all other predictors constant at their means, an increase in program participation from one standard deviation below the mean to one standard deviation above the mean is associated with an increase of about 6 percentage points in the probability that a pregnant woman would choose abortion (from 18.7 percent to 24.5 percent, using column 1).[20] This positive relationship persists across various specifications of the model.

While increased welfare program participation is positively related to an abortion decision for women of all four combinations of race and marital status, the magnitude of the relationship is uneven (column 4). Welfare program participation and abortion are

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[20] Predicted probabilities were computed with CLARIFY 2.1 (Tomz, Wittenberg, and King 2003).

Table 4.3. Social Welfare and Other Factors in Women's Abortion Decisions

	(1)	(2)	(3)	(4)	(5)	(6)
Number welfare prgms.	1.921*	1.873*		2.242	1.788	
State welfare generosity	1.002***	1.002***		1.002**	1.002*	
Benefits cut/not received			0.922			1.376
Private assistance		1.135		1.247	1.354	
Expected support		0.880		0.662	0.966	
Economic hardship	1.581**	1.537**	1.641**	1.587	1.240	0.914
Abortion access	1.428***	1.429***	1.407**	1.395***	1.063	1.008
Family planning access	1.537	1.539	1.773	1.605	9.143***	10.717***
Employed or in school	1.871***	1.874***	1.782**	1.846***	2.476***	1.910*
Less than HS diploma	0.851	0.850	0.795	0.828	0.536*	.613
Some college	0.789	0.797	0.779	0.777	0.827	1.242
College graduate	0.810	0.810	0.445	0.787	--	--
Married	0.327***	0.329***	.026***	0.843	0.426	0.297*
Black	1.680***	1.671***	1.785**	3.496	1.680	1.602
Number of children	0.709***	0.708***	0.718***	0.698***	0.606***	0.626***
Age	1.041*	1.041*	1.047*	1.046**	1.078**	1.083*
Religious	0.694*	0.695*	1.008	0.711	0.729	0.807
Domestic abuse	1.818**	1.803**	1.403	1.851**	1.113	0.960
Number welfare prgms*black				0.569		
State welfare generosity*black				0.999		
Number welfare prgms*married				0.899		
State welfare generosity*married				0.999		
Number welfare prgms*black*married				41.705*		
State welfare generosity*black*married				1.001		
Private assistance*black				0.834		
Expected support*black				1.756		
Economic hardship*black				0.981		
Black*married				0.091		
N	832	832	557	832	273	216

Figures are odds ratios from logistic regression. *p<.10, **p<.05., ***p<.01, two-tailed tests.

more tightly linked among black married women than any other demographic group. Since the effects of a single variable become increasingly difficult to interpret as two- and three-way interactions are added to logistic regression models, a comparison of predicted probabilities sheds more light on the association between welfare participation and

abortion for each group. When moving from one standard deviation below each group-specific mean for program participation, the predicted increases in the probability of abortion are 2.3, 6.6, and 2.2 percentage points for black unmarried women, white unmarried women, and white married women, respectively. For black married women, however, the increase in welfare participation is associated with a statistically significant ($p<.05$) 15.8 percentage point jump in the probability of choosing abortion, from 3.8 percent for those at one standard deviation below the mean to 19.6 percent.

The hypothesis that social welfare programs reduce the likelihood of abortion is also soundly rejected when considering the generosity of state safety nets. In all specifications for the full sample, women's probability of choosing abortion significantly increases with their state's per capita welfare spending. Using column 1, the estimated probability is 17.6 percent in states one standard deviation below the mean welfare spending ($509 per capita, similar to California's cost-of-living adjusted spending) but 26.0 percent in states one standard deviation above the mean ($815 per capita, similar to Massachusetts' adjusted spending). When allowed to vary by race and marital status (column 4), the change in predicted probabilities is significant only for unmarried white women, raising their probability of abortion by 12.4 percentage points.

When the sample is narrowed to pregnant women who are or believe themselves to be eligible for welfare, food stamps, or child care subsidies, the direction of the welfare effect also defies expectations of the capacity-building theory (column 3). The group expected to be worst off—women who have lost some or all of their cash welfare benefits for program noncompliance, who have had their applications for assistance turned down,

or who did not apply for assistance—actually appears slightly *less* likely to choose abortion than women currently receiving assistance at their full benefit levels.

It remains possible that program participation still captures poverty's effect. Repeating analysis only on respondents in the bottom third of the income distribution yields a mixed judgment. Significance levels for welfare program participation and state welfare generosity drop with the smaller sample, but the sizes of the odds ratios change little (column 5). The direction of the welfare effect, however, does conform to expectations among the lowest-income, assistance-eligible women (column 6). For them, a loss of benefits or a failure to obtain assistance is associated with an increase in abortion incidence, estimated at 5.8 percentage points.

The nongovernmental safety net has an ambiguous and, for the most part, statistically insignificant relationship with women's odds of choosing abortion. Women who know they can count on someone for help when in a bind are somewhat less likely to choose abortion (column 2), but the odds ratio on private assistance received behaves differently. An increase in the number of sources from which a family receives nongovernmental assistance is positively (though not significantly) related to the odds of choosing abortion. Substantial correlation between this measure and the scale of public assistance received (ρ=.45) suggests that public and private assistance complement, rather than substitute for, each other. No statistically significant differences emerge when the effect of the private assistance is allowed to vary by race.

The estimated effects of control variables are consistent across models and generally in the expected direction, with only a few exceptions. A woman's likelihood of choosing abortion is strongly and positively related to the accessibility of abortion

services in her state. The predicted probability of choosing abortion climbs sharply, from 16.2 percent to 28 percent, when moving from one standard deviation below the mean for abortion access to one standard deviation above the mean and setting other variables in column 1 at their means. Women currently employed or in school are considerably more likely to abort. Black women and unmarried women have significantly higher odds of ending a pregnancy in abortion, while the odds are marginally lower for churchgoing women. All else equal, the odds of abortion decrease substantially with each biological child, perhaps representing women's relative preference for motherhood, though they do increase with age. With other controls in place, educational attainment is not significantly related to the abortion decision except when considering the least educated of the lowest-income women. Women with a recent history of domestic abuse are more likely to turn to abortion.

The one relationship that differs noticeably from expectations is that between family planning access and women's abortion decisions. Women living in states whose public policy has made contraception more affordable are actually more likely to resolve a pregnancy in abortion. Part of this story may be the correlation between state family planning policy and state abortion policy (ρ=.65). Also, the measure does not reflect individual contraceptive decisions.

In an attempt to explain the unexpected positive relationship between social welfare programs and abortion, I next consider that public assistance clients may be receiving cues from caseworkers and program rules that may encourage or facilitate pregnancy termination. As previously discussed, some believe a family cap would increase abortions among welfare recipients because benefits would be spread more

thinly in the family. Passage of a family cap may also signify a state welfare bureaucracy's orientation toward discouraging childbearing, one that may manifest itself in subtler ways relating to how caseworkers deal with their clients.

A second policy I consider is whether state law prohibits certain public employees from providing abortion information or referrals, since it is plausible that some caseworkers may routinely distribute this information to their pregnant clients. This type of policy is of still more recent vintage, as most states had just begun passing these laws in the late 1990s. There is also considerable variation in the scope of public employees or grantees covered by the law, and public assistance caseworkers are never explicitly mentioned. Nevertheless, if at least some social service providers who interact with assistance recipients are forbidden from discussing abortion, the relationship between abortion and welfare program participation may diminish.

Table 4.4 shows results from models that incorporate these laws and interact them with a woman's welfare program participation. We see some support for the hypothesis that state welfare bureaucracies mediate the relationship between welfare and women's abortion decisions. The welfare-abortion link is magnified for women living in states with family caps and diminished in states with restrictions on public employees' abortion counseling. Again, predicted probabilities ease interpretation. The welfare participation of women living in states with family caps (from one standard deviation below to one above the mean) is associated with a 6.8 percentage point increase in the probability of choosing abortion, while this increase is about half a percentage point in states without family caps. For women living in states that do not prohibit public employees from providing abortion information or referrals, the 2-standard deviation

increase in welfare program participation predicts a significant (p<.05) 8.8 percentage point increase in the probability of choosing abortion. While not attaining statistical significance, there is a 4.7 percentage point *decrease* in the probability of choosing abortion associated with welfare participation in states that limit public employees' discussion of abortion.

Table 4.4. Welfare Bureaucracies and the Abortion-Social Welfare Link

	(1)	(2)
Number of welfare programs	1.435	2.532**
Family cap	0.491*	
Family cap*programs	1.510	
Counseling ban		1.755
Counseling ban*programs		0.196*
State welfare generosity	1.001	1.001**
Abortion access	1.499***	1.390***
Family planning access	1.983	1.561
Economic hardship	1.575**	1.624***
Employed or in school	1.913***	1.823***
Less than HS diploma	0.852	0.875
Some college	0.788	0.808
College graduate	0.821	0.855
Married	0.311***	0.329***
Black	1.773***	1.724***
Number of children	0.714**	0.709***
Age	1.038*	1.040*
Religious	0.705	0.705
Domestic abuse	1.837**	1.854**
N	834	834

Figures are odds ratios from logistic regression. *p<.10, **p<.05., ***p<.01, two-tailed tests.

4.3 Discussion

This study indicates that abortion is a more common pregnancy resolution among women who are severely economically disadvantaged and women whose balance between work and family has been particularly stressful. But contrary to the hypothesis that social welfare programs would build the capacity of low-income women to choose childbearing, this study found that access to and participation in social welfare programs

predicted an *increase* in the probability that a pregnant woman would choose abortion, at least among low-SES, urban women with at least one child. Does this study vindicate the Republican platform of restricting welfare spending as well as abortion access? Not necessarily—such a conclusion would be premature in light of the rest of this study's results and other possible explanations of this finding.

First, welfare bureaucracies appear to condition the existence and magnitude of a relationship between program participation and abortion. As a woman's exposure to the welfare system increases, so does her potential for exposure to cues regarding her reproductive decisions. The odds of resolving a pregnancy in abortion increase considerably for program participants living in states that deny additional assistance to new children born to welfare families or whose public employees are not constrained by law from providing abortion information to clients. Meanwhile, increased program participation does not affect the probability of choosing abortion among women in states without family caps, and it may even decrease abortion usage in states where some public employees or grantees are forbidden from abortion counseling. How actively caseworkers encourage or facilitate welfare clients' abortions, and whether these activities help women achieve their true reproductive preferences or pressure them out of childbearing is a matter for future research.

Differences by race and marital status in how program participation and welfare access are linked to abortion usage also suggest that it is not necessarily public assistance itself that encourages abortion. While positive for all groups, these findings are driven by the experience of married black women and unmarried white women. This too bears further investigation, but it may have something do with other, less measurable correlates

of abortion, such as women's visions of their futures (Feldt 2002; Swope 1998). In American society, married black women and unmarried white women generally may fall somewhere between the other two groups in their prospects for future economic security. These groups of women may be on the cusp of "making it," but heavier reliance on public assistance may signify a tenuous hold on these prospects. For these women especially, an additional child may appear to make or break their economic futures.

One may argue that the present analysis has still not adequately separated welfare participation from economic hardship, especially considering the positive relationship observed between receipt of private aid and the odds of choosing abortion. On the other hand, this sample's receipt of private and public assistance are related. Public agencies have long partnered with nongovernmental organizations to deliver services to the poor (Salamon 1995), while the 1996 welfare reform and President Bush's faith-based initiative have continued to encourage this practice. We cannot know from these data how much private assistance women received in this fashion. Additionally, similarities in results when welfare generosity is measured at the state rather than the individual level weigh against the hardship explanation.

Other possible reasons for abortion's link with welfare participation and welfare generosity cannot be directly tested with these data and may be avenues for future research.

One concerns the aforementioned size of welfare benefits in the United States. Scholars have called the United States unusually stingy in its welfare spending relative to other developed countries (Skocpol 1995). In this sample, welfare checks averaged $324 a month. This relatively small amount of assistance is probably not enough to truly help a

poor woman afford another child (Edin and Lein 1997). It may be enough, however, to help her afford the abortion she may not otherwise have been able to pay for, especially in states where Medicaid does not fund the procedure. This situation is perhaps the most plausible explanation for the link between state welfare generosity and abortion usage. Since interstate variation in welfare benefits is relatively small and exhibits spatial patterns (Schram, Nitz, and Krueger 1998; Volden 2002), one must likely look outside U.S. borders to find a welfare state whose benefits are effectively "capacity-building."

The time frame of this study may also influence the direction of the findings. The Fragile Families study was fielded entirely during the post-welfare reform era. Welfare recipients were subject not only to provisions like the family cap, but to more rigorous work requirements, to limits on their lifetime years of welfare receipt, and a dizzying array of rules related to "personal responsibility" whose violation could result in a loss of benefits. At the time of these interviews (1999-2002), the two-to-five year clocks set by states for lifetime benefit receipt were beginning to expire. In theory, welfare recipients faced greater uncertainty about their future since they were no longer legally entitled to public assistance, and this prospect may have led many to exercise more caution in their childbearing. While a study has yet to establish a causal or even correlational role for welfare policy, poor women made up a noticeably larger share of abortion patients in 2000 than they had in 1994, before welfare reform (Finer et al. 2005; Jones, Darroch, and Henshaw 2002).

Factors influencing selection into welfare programs may also moderate participation's link with abortion. In order to establish and maintain their eligibility for assistance, program participants must be aware of the assistance available, know program

rules, and stay on top of volumes of paperwork (Hays 2003). Women who display this level of information savvy are likely also more capable of acquiring information about how to obtain a desired abortion. If welfare recipients share common social networks, they may also be able to share this latter information with each other.

Finally, though this research finds no statistically significant evidence that welfare programs build the capacity of urban, low-SES mothers to choose childbearing, this may not necessarily be the case among other women, especially those with no prior children. The women in this sample know firsthand the challenges of childrearing, as well as the rewards. The marginal increases in public assistance—if any—may make less of a difference to the budgets of families already in the system than they would for women whose entrance into motherhood qualifies them for a large range of assistance programs. This may especially be the case for women whose employment prospects are especially bleak.

Additional limitations of this research design also caution against the conclusion that welfare programs *encourage* abortion. This analysis is correlational, not causal. We know only that respondents reported a particular pregnancy outcome within the previous 12-18 months and particular experience with the social welfare system or with hardship in the previous 12 months. We do not know that these events were related or even the order in which they occurred over that time period. Respondents may not have applied for child care subsidies or for food stamps until after terminating a pregnancy. Nevertheless, this is a drawback shared by many studies using survey research, and these data appear to be the best available for studying this question.

Finally, the theory itself could be wrong. Women's pregnancy decisions may be still less sensitive to costs than believed. Welfare benefits may be capacity-building in other aspects of an individual's life, but not in decision-making that is so deeply personal (though highly politicized) as the decision between abortion and childbirth.

In this study, the authority tool—abortion regulations and provider supply—appeared considerably more effective at reducing abortions than the capacity-building tool, social welfare programs. Of course, this study has not tested whether women in states with more restrictive abortion policy are forgoing abortions they would have otherwise preferred. It could be that more restrictive abortion policy simply indicates lower tolerance of abortion among political elites and the mass public (Gerber 1996; Wetstein 1996), but my focus on enforcement rather than passage of a law should mitigate this concern. Low-income mothers living in states with more restrictive abortion policy climates are less likely to choose abortion. Regardless of the mechanism by which these laws work—by actually preventing women from obtaining abortions, as their opponents contest, or by changing women's minds, as proponents argue—state abortion policy appears highly relevant to women's decisions. But we cannot entirely dismiss cultural explanations. The unexpected positive coefficient on family planning access, for example, may be joining abortion policy in tapping into the liberality of a population's sexual attitudes. Some economic models have connected these attitudes as well as the prevalence of abortion and contraceptive use to increased sexual activity and thus increased opportunities for unintended pregnancy (Akerlof, Yellen, and Katz 1996).

Clearly state policy appears related to individual behavior, even in behavior as personal as childbearing and abortion. This is the case regardless of policy tool, capacity-

building or authority, though the hypothesis that welfare participation and generosity should reduce abortion was not supported for this sample. Our ability to reach a more general verdict on the politically attractive argument that welfare is “pro-life” may ultimately require comparative data that do not yet exist, or much greater expansion and variation in the American states’ welfare efforts.

Chapter 5: Abortion Decisions in Real and Hypothetical Welfare States

Findings in the previous chapter shed some light on the association between childbearing decisions and receipt of public and private social services. They leave several questions unanswered, however, and also generate some new lines of inquiry. The first question, posed in chapter one, concerns how decisive the role of economic resources is in women's childbearing decisions. While previous research has documented that financial constraints rank among the most important reasons why women choose abortion, it has not tested whether these constraints are so paramount that women would choose differently if they had access to a range of economic resources that government does, or could, provide.

The previous chapter also offered several explanations for the finding of a positive relationship between welfare program participation and low-income women's likelihood of choosing abortion. Among them was that current American welfare programs were not generous enough to make a meaningful difference in women's ability to afford children. The additional funds provided by public assistance may help in securing an abortion, but it would take much more expansive assistance programs for economically disadvantaged women to truly feel at liberty to choose childbearing. Chapter four's research design was also unable to comment on a possible causal or even temporal connection between respondents' experience of economic hardship and welfare program participation, and their pregnancy decisions.

I attempt to tackle these and other questions in the present chapter, employing data from a survey I conducted at the offices of abortion providers and pregnancy centers

in the Baltimore, MD metropolitan area. With these data, I address the relative importance of economic constraints in the decision-making of women experiencing unintended or problem pregnancies, by their choice of abortion or parenting. I also reassess the association between welfare program participation and abortion, and discuss women's perceptions about how their access to economic assistance did affect or might have affected their pregnancy decision. Women who chose parenting are asked whether they would have instead chosen abortion in the absence of the economic assistance they received, while women who chose abortion are asked whether they might have continued their pregnancy if they had had access to the types of assistance characteristic of a European-style welfare state. Finally, I also consider the demographics of economic constraint on childbearing decisions, looking at the extent to which socioeconomic status, race, and other factors are related to the importance of financial limitations and women's reports that they would have decided differently in the presence or absence of economic assistance.

I continue to find mixed support for this project's guiding hypotheses. While economic need is only one of many important considerations in women's childbearing decisions, the existing public-private safety net nevertheless appears to have prevented some abortions. Results further suggest that expansion of that safety net would result in fewer abortions, though implementation of the expansions considered figures to be highly implausible in contemporary American politics. The welfare state is and could be making the most difference to the decisions of the socioeconomically disadvantaged—financially needy women and black women. On the other hand, objective economic need does not appear to distinguish women choosing childbirth from women choosing abortion.

Abortion opinion, religious practices, and orientations toward motherhood do, as does, among the lower-income segment of the sample, subjective assessments of need.

5.1 Data

Chapter one introduced the pregnancy decision-making survey. Copies of the survey instrument are reprinted in the appendix.

5.1.1 The Relevance of Survey Location

Since the survey was conducted in only one geographic area, the Baltimore, Maryland metropolitan area, findings are technically generalizable only to this area. Maryland and the Baltimore metropolitan area differ systematically from other geographic areas in several ways that are important for this study. First, both abortion services and public assistance are at least in theory more accessible here than in many other locations. Maryland's policy with respect to reproductive rights is among the most liberal in the country, earning the state an A grade for 2005 from NARAL Pro-Choice America. The state's Medicaid program covers pregnancy termination (NARAL Pro-Choice America Foundation 2005). Nearly 100 percent of the state is coded by the Census as falling in a metropolitan area, and with 24 percent of women living in counties without an abortion provider (compared to 34 percent nationally) the supply of abortion providers appears to exceed most states (Finer and Henshaw 2003). Maryland does not mandate waiting periods or the provision of certain information to women seeking abortion. While Maryland technically requires notification of one parent prior to a minor's obtaining an abortion, the law specifies a number of instances in which the doctor performing the abortion may choose not to give notice, including his or her belief

that the minor is sufficiently mature to have made her own decision about her pregnancy (NARAL Pro-Choice America Foundation 2005).

Perhaps in part due to its more liberal welfare and work-family policies, Maryland ranks near the top in many organizations' ratings of states on the well-being of women and children. The Institute for Women's Policy Research gave Maryland B+'s for women's employment and earnings as well as women's social and economic autonomy (Werschkul and Williams 2004). *Working Mother* magazine has consistently rated Maryland among the 10 Best States for Child Care (Holcomb, Dreisbach, and Hutter 1999). Maryland ranks in the top five states for the lowest percent of children, the population, and single-parent families in poverty (Annie E. Casey Foundation 2005), and based on various indicators of child health and safety, was recently named among the 10 best states to raise a child (Govspot.com 1999).

Following the passage of federal welfare reform, Maryland declined to adopt work requirements and time limits that were stricter than the federal minimum (Soss et al. 2001). While Maryland initially implemented a modified family cap that provided in-kind assistance to families via a third party in lieu of increasing a family's grant, every county had ceased enforcing the family cap by the fall of 2002 (Levin-Epstein 2003). Maryland appears somewhat less generous with regard to cash welfare benefits and eligibility standards for this program, falling around the middle in a state-by-state ranking of maximum cash grants and toward the bottom for income levels at which families are eligible for cash welfare (Administration for Children & Families 2004). Health care is somewhat more accessible. Maryland's income eligibility standards for Medicaid and the

State Children's Health Insurance Program rank among the upper-middle for their expansiveness (National Governors' Association 2005).

Because of Maryland's relatively generous policy on access to abortion and public assistance and its higher socioeconomic standing among the states, the childbearing decisions of women in the study should be less constrained by need and public policy than the decisions of women in other states. If expectations of social welfare as capability-building are correct, the data thus probably understate the national percentage of women who consider or turn to abortion out of economic reasons and who would make different decisions about their pregnancies under a more expansive welfare state. Likewise, I expect that these data may overstate the national percentage of women for whom receipt of public and private economic assistance was key to their decision to deliver and raise a baby.

5.1.2 The Sample

In all, 108 useable surveys were collected, 45 from women choosing childbirth and 63 from women choosing abortion.[21] The distribution of pregnancy decisions in the sample, then, does not quite approximate the distribution of decisions nationally, in which half of all unintended pregnancies (excluding miscarriages) are estimated to end in abortion, half in birth.

Neither group of women adequately represents the national population of women undergoing abortion or unintended births. Unfortunately, neither is the bias consistent across groups, as the demographics of my sample of abortion patients more closely track

[21] An additional thirty surveys (19 from pregnancy centers and 11 from abortion providers) were collected but could not be used. In most cases, a questionnaire was discarded because the informed consent form had not been completed or because the respondent listed her age on the form as less than 18 in spite of agreeing to a contrary statement on the consent form.

national statistics on abortion patients than do the demographics of the childbirth group. Table 5.1 reports demographic characteristics on both groups of women. It also includes statistics for a subgroup of abortion patients from which all respondents with incomes above the childbirth sample's maximum have been removed (women whose household incomes exceed $55,000, approximately the Maryland median income in 2004). In the following paragraphs, I describe respondents' characteristics and compare them when possible to two sets of national statistical estimates. These are the demographics of births and abortions following unintended pregnancy from the 1994 National Survey of Family Growth (tabulated by Henshaw 1998b) and the characteristics of U.S. abortion patients from a 2000 Alan Guttmacher Institute study (Jones, Darroch, and Henshaw 2002).

In neither group were all pregnancies unintended. Among the 63 abortion patients, two women reported that their pregnancies had initially been planned, while among the childbirth sample, ten women (22 percent) reported that they had been planning to conceive. Eighty-four percent of the abortion group and 56 percent of the childbirth group reported that the pregnancy was unplanned, and the remaining women in each group chose their third response option—that they had not been planning to get pregnant, but had been open to the idea. I confine some of the foregoing analysis to women in these latter two groups, but more often work with data from all respondents and control for intention. This allows me to maximize degrees of freedom and account for the possibility that changes in economic circumstances or the availability of assistance might have tempted or led some women to abort initially planned pregnancies.

With regard to age distribution (not including minors), my samples match up fairly well with national statistics. The abortion group nearly mirrors the age distribution

Table 5.1 Baltimore Sample Demographics

	Childbirth Sample	Abortion Sample	Abortion Sample (Low-Income)
Pregnancy intention			
Unplanned	55.6	84.1	88.1
Unplanned, but open to idea	22.2	12.7	11.9
Planned	22.2	3.2	0.0
Age			
18-19	17.8	11.1	11.9
20-24	28.9	30.2	40.5
25-29	22.2	23.8	21.4
20-24	15.6	19.1	21.4
35 and above	15.6	15.9	4.8
Marital Status			
Currently married	13.3	20.6	14.3
Divorced/separated/widowed	11.1	14.3	9.5
Never married	75.6	65.1	76.2
Race			
Black (incl. Black Latina)	75.6	47.6	54.8
White	17.8	44.4	35.7
Other	6.6	7.9	9.5
Household Income			
Less than $10,000	48.8	17.5	26.2
$10,001025,000	41.5	14.3	21.4
$25,001-$40,000	4.9	20.6	31.0
$40,001-$55,000	4.9	14.3	21.4
$55,001-$70,000	0.0	12.7	0.0
$75,001-$85,000	0.0	4.8	0.0
$85,001-$100,000	0.0	6.4	0.0
More than $100,000	0.0	9.5	0.0
Education			
Less than high school	35.6	3.2	4.8
High school diploma or GED	42.2	30.2	38.1
Some college or 2-year degree	17.8	34.9	38.1
Bachelor's degree or higher	4.4	31.7	19.1
Student status at survey			
Full-time student	11.1	15.9	19.1
Part-time student	4.4	15.9	23.8
Not a student	84.4	68.3	57.1
Employment status at survey			
Employed full-time	22.7	60.3	57.1
Employed part-time	11.4	20.6	23.8
Not employed; looking for work	52.3	11.1	14.3
Not employed; not looking for work	13.6	7.9	4.8
Children at time of pregnancy			
0	33.3	49.2	52.4
1	26.7	30.2	28.6
2	26.7	17.5	16.7
3 or more	13.3	3.2	2.4

Public assistance receipt			
Yes, at pregnancy	66.7	14.3	19.1
Yes, at survey	93.3	20.6	23.8
Abortion opinion at pregnancy			
Pro-life	44.2	14.3	14.3
Pro-choice	9.3	74.6	73.8
Don't know	46.5	11.1	11.9
Church attendance			
Once a week or more	35.6	20.9	19.5
At least once a month	15.6	12.9	12.2
A few times a year	37.8	38.7	31.7
Never	11.1	27.4	36.6
N (Maximum nonmissing values)	45	63	42

Abortion sample (low-income) refers to abortion patients reporting annual household incomes of $55,000 (approximately Maryland median household income) or less.

of abortions after unintended pregnancy in 1994, and is similar to the age distribution of abortion patients in 2000 except for including more 30-34 year-olds and fewer women aged 35 and older. The childbirth group contains a smaller proportion of 20-24 year-olds than found among national statistics on unintended births, but none of the age groups are seriously over- or under-represented.

Considering marital status, the distribution of the abortion sample also matches up well with national statistics. In this sample and in both sets of national statistics, two-thirds of abortion patients have never been married. When distinguishing between currently and formerly married abortion patients, my sample contains a larger share of currently relatively to formerly married women. The distribution of marital status in the childbirth sample is more skewed, however. National statistics on unintended births indicate that 49 percent should be to never-married women; in my sample, 80 percent of the women with unplanned pregnancies had never been married.

Important differences between these samples and national statistics also emerge with regard to respondents' race and household income. Both groups of women in my

sample include larger proportions of black women than do national statistics—to some extent, this is expected since Maryland's black share of the population is more than double that of the United States.[22] The two groups of women in my survey, however, are not equal in the extent to which black women are overrepresented. Black women represent about a third of respondents in both sets of national abortion statistics, but half of respondents in my group of abortion patients. Meanwhile, 26 percent of unintended births are to black women, but they make up 80 percent of respondents in my childbirth sample.

Nationally, just over half of abortions in 1994 were estimated to have been by women in households with incomes of less than 200 percent of the federal poverty line; this estimate rose to 57 percent of abortion patients in 2000. My abortion patient sample appears better off economically, with only a third choosing income categories that roughly correspond to less than 200 percent of poverty line for a household of one adult and one child. This comparison is fairly rough, however. Maryland's median income exceeds that of nearly every other state. A second reason for the inexact comparison is that the federal poverty line varies based on household size, and my survey did not ask respondents the total number of people in their households. With these same caveats in mind, 65 percent of unintended births in 1994 were to women with household incomes below 200 percent of the poverty line; in my sample 87.5 percent of women with

[22] Blacks constituted 12 percent of the U.S. population and 28 percent of the Maryland population in Census 2000. They made up 64 percent of Baltimore City's population and 20 percent of the population of Baltimore County, the suburban jurisdiction that surrounds but does not include Baltimore City.

unplanned pregnancies reported household incomes below roughly 200 percent of the poverty line.[23]

Additional demographic characteristics for abortion patients only are available from the 2000 Alan Guttmacher Institute study (Jones, Darroch, and Henshaw 2002). On the whole, my sample appears to be more highly educated than abortion patients nationwide. Much of this difference results from the exclusion of women younger than 18 from my study; this group made up 7.2 percent of abortion patients in 2000. Additionally, Maryland ranks among the best states in the nation for educational attainment. In my sample, 32 percent of abortion patients hold at least a 4-year college degree, 35 percent have some college but no 4-year degree, while 3 percent have less than a high school education. The childbirth group is less well-educated: 36 percent have not earned a high school diploma or GED, 4 percent hold at least a 4-year college degree, and 18 percent have some college experience but no 4-year degree.

Commensurate with their higher socioeconomic standing, my sample of abortion patients also includes a smaller share of Medicaid recipients than national statistics show: 13 percent, as opposed to 24 percent. This latter figure had been trending downward in 2000, however, and the percentage of Medicaid recipients among abortion patients might have been expected to drop further by 2005 considering that national and state governments, including Maryland's, have recently made some highly publicized cuts in Medicaid eligibility. Sixty-four percent of the childbirth sample was receiving Medicaid at the time of their survey, but this figure is inflated because many women became eligible for the program by virtue of giving birth. About 30 percent of these women had

[23] The poverty line for a family of one adult and one child was approximately $26,000 in 2004. I asked for respondents' incomes in terms of categories, and so have calculated this estimate for my sample using women selecting categories below the $25,000 cutpoint.

not been participating in any welfare program before they became pregnant. Upon finding out about their pregnancy, 67 percent of the childbirth group and 14 percent of the abortion group had been participating in at least one welfare program: cash assistance, food stamps, Medicaid, housing assistance, child care subsidies, or the Women, Infants, and Children Nutrition Program (WIC). This gap does not narrow appreciably when considering only women with prior children.

Women choosing childbirth have more children than women choosing abortion. Half of abortion patients in my sample and 39 percent of abortion patients in 2000 had no prior biological children, though it is possible that my statistics could be missing some biological children since women were asked about the number of children they cared for in their home, then about how many of them they had given birth to. With the same caveats, the pregnancy under consideration was the first biological child for 36 percent of the childbirth sample. In the abortion group, no woman reports more than three children. Thirteen percent of the childbirth group reports more than three children. A small number of women in each group care for children that are not their biological children.

Religious affiliations of my abortion patient sample match up reasonably well with national statistics; no comparable figures are available for women choosing childbirth. Eight women in the abortion group and nine women in the childbirth group did not answer the open-ended question about their religious denomination. Of the remaining women, 16 percent of abortion patients and 6 percent of pregnancy center clients reported no religion or atheism as their religious affiliation. Twenty-two percent of abortion patients nationally report no religious affiliation. Just over a quarter of each group was Catholic, mirroring the proportion of Catholics among all women of

childbearing age and among abortion patients in 2000. The remainder of the childbirth group indicated a Protestant denomination or identified as "Christian", excepting two who did not know their religious affiliation. In the abortion group, 7 percent are Jewish and the rest named a Protestant denomination or identified as "Christian."

We might expect that pregnancy decisions are constrained by women's attitudes toward abortion, and that these attitudes might be correlated with other indicators of traditionalism such as church attendance. My statistics show that the childbirth sample is indeed more pro-life and more devout. I measure attitudes toward abortion with a common Gallup poll question asking respondents to identify as "pro-life" or "pro-choice" with respect to the legality of abortion. Three-quarters of the abortion group but only 9 percent of the childbirth group identifies as "pro-choice." Remaining respondents in both groups are split roughly equally between the proportion that identify as "pro-life" and the proportion that checked the "don't know" option. Women were asked to give what their opinion had been before they became pregnant, to rule out the possibility that this particular experience of pregnancy and abortion or motherhood may have affected their opinions. Thirty-six percent of women choosing childbirth attend religious services at least once a week, compared to 21 percent of the abortion sample. Eleven percent of the childbirth sample and 27 percent of the abortion sample reports never attending church. No comparable national statistics for either group appear to be available.

Also, without the benefit of comparison to published national statistics, there are stark differences in the employment and educational statuses of the two groups of women. Sixty percent of abortion patients were employed fulltime, compared to 23 percent of women in the childbirth sample. Only 19 percent of the abortion sample was

not employed, less than half of whom reported not looking for work. In the childbirth sample, 66 percent were not employed, though a sizeable majority of those women reported that they were looking for work. To some extent this may be a function of when the question was asked. One might expect women who have recently given birth to be less likely to be currently employed, though this likely does not account for the employment disparity between these two groups. Women were not asked about their employment or their educational status at the time they became pregnant. This also may explain some, though certainly not all, of the difference between the two groups in the proportion of students they include. The groups are not far apart in the proportion of full-time students they include—16 percent among the abortion group and 11 percent among the childbirth, but the abortion group does include more part-time students, 16 percent versus 4 percent.

While the childbirth sample had initially been expected to be of lower socioeconomic status than the entire population of women giving birth after unplanned pregnancy, the size of the childbirth-abortion gap in SES, race, and marital status had not been anticipated by the research design. Partly this may be a function of variation by study site in the percentage of surveys collected that were useable. A number of surveys collected by the pregnancy centers and abortion clinics had to be discarded because some respondents failed to check and date the informed consent box on the front of the survey packet. Among the pregnancy centers, the site expected to cater to the least well-off clientele was the best at producing useable surveys. Most likely this was because this site appeared to have a better ratio of staff to clients as well as having more paid employees and volunteers with regular shifts. This may have led to greater familiarity with the

survey, with eligibility criteria, and with developing a practice of reminding respondents about the informed consent box. The two least effective sites were in whiter, higher-SES (relatively speaking) parts of town and appeared to have considerably smaller, more volunteer-based staffs that may not have developed the same familiarity with the survey. Among the abortion providers, in contrast, the lowest percentage of useable surveys came from the site most likely to serve a lower-SES clientele. While professionally staffed like all of the participating provider offices, it was by far the biggest and busiest site of the three and many different staff members were responsible for administering the survey. My contact at this site believes this may have contributed to lack of familiarity with the survey on the part of any given staff member as well as time pressures that may have resulted in somewhat decreased attentiveness to survey criteria.

5.2 Results

5.2.1 Hardship, Welfare Receipt, and Abortion: A Limited Reassessment

Given the more systematic bias in one half of the sample, I am severely limited in what I can conclude about the factors predicting pregnancy resolution. Results from a logistic regression model predicting an abortion decision are nevertheless reported in Table 5.2. As in the previous chapter, the dependent variable is a dummy variable equaling 1 if the respondent had been an abortion patient.

Column 1 presents a model designed to be as comparable as possible to the basic model from chapter four, but the research designs and data availability mandate some important differences. Public policies on abortion, welfare, and family planning are not

Table 5.2 Logistic Regression Model of the Decision to Abort

	(1)	(2)	(3)
Welfare receipt at pregnancy	--	--	-2.06 (1.26) 0.127
Welfare programs after pregnancy	-15.69*** (4.58) 0.000	--	--
Struggles to afford basic needs	0.78 (0.77) 2.19	--	--
Income	--	1.05** (0.43) 2.87	1.18 (0.53) 3.26
Employed or in school	1.92** (0.80) 6.83	2.88** (1.14) 17.81	2.45** (1.13) 11.61
Married	0.10 (0.94) 1.10	3.87** (1.81) 47.83	3.31* (1.76) 27.47
Black	-0.66 (0.83) 0.52	-1.23 (1.11) 0.29	-0.32 (1.32) 0.73
Children at time of pregnancy	-0.29 (0.45) (0.75)	-0.04 (0.56) 0.96	0.05 (0.62) 1.06
Age	-0.05 (0.07) 0.95	-0.14 (0.10) 0.87	-0.20* (0.11) 0.82
Less than HS	-1.07 (1.22) 0.341	--	--
Some college	1.33 (0.83) 3.79	--	--
College degree	2.49* (1.29) 12.07	--	--
College experience	--	1.32 (0.97) 3.74	1.54 (1.05) 4.69
Church attendance	-1.72** (0.83) (0.18)	--	--
Pro-life attitudes and social support for birth	--	-6.99*** (1.98) 0.00	-8.04*** (2.26) 0.00
Planned pregnancy	--	-3.96** (1.58) 0.02	-3.33** (1.60) 0.04

Constant	2.02	3.89	5.90**
	(1.96)	2.55	(2.92)
Pseudo R-squared	0.55	0.70	0.73
N	106	101	101

Table reports logit coefficients, with standard errors in parentheses, followed by odds ratios. *p<.10, **p<.05, ***p<.01 (two-tailed).

controlled as the survey was conducted entirely in Maryland.[24] Since my survey did not include questions comparable to the indicators of economic hardship and inability to afford basic needs found in the Fragile Families study, I attempt to get at this concept with a dummy variable coded 1 if the respondent reported that her struggles to afford her family's basic needs were a "very important" reason for the abortion or concern during the pregnancy. My survey did not ask respondents about their experience with domestic abuse.

Many of the coefficients in column 1 go in the directions one might expect given the sample's bias. Welfare program participation, which is measured here as a 0-1 scale of the number of public assistance programs[25] from which a respondent receives help, now strongly predicts that a woman will choose birth rather than abortion. In this dataset, however, this variable is considerably more problematic than it is in the Fragile Families study. Women were asked to identify the specific programs from which they received assistance only at the time of the survey, not at the time of their pregnancy. Not only are women more easily eligible for a wider range of welfare programs by virtue of having children—which all women in the childbirth sample by definition do—but having an infant rather than an older child also increases eligibility for some welfare programs, such

[24] Respondents were not asked if they lived in another state, but this is not likely considering women coming to Maryland from neighboring states for services would have had closer locations than Baltimore.
[25] This number is out of six possible programs: cash welfare, food stamps, Medicaid or the Children's Health Insurance Program, WIC, housing assistance, and child care subsidies. Respondents were not asked about the Earned Income Tax Credit as they were in the Fragile Families study.

as Medicaid and WIC. Contact with a pregnancy center may also increase the likelihood that an eligible client would obtain assistance from more welfare programs, and several respondents did indicate that they had visited a pregnancy center before the birth of their child. Many pregnancy centers display information about welfare programs and train their staff to assist women in accessing public assistance. Combining these considerations with the unexpected under-representation of public assistance recipients in the abortion sample, I have little confidence that this model can establish an accurate estimate of the association between extent of welfare program participation and childbearing decisions.

The other significant predictors in this model are women's work and school status, education, and church attendance. Consistent with arguments about the greater opportunity costs that would be incurred by employed women, students, and especially highly educated women, respondents who are currently employed or studying on at least a part-time basis and respondents with at least a four-year college degree are significantly more likely than other women to choose abortion. Weekly attendance at religious services is associated with a lower likelihood of choosing abortion.

Struggles to afford basic needs are positively but not significantly related to the probability that a woman would choose abortion. Signs on the coefficients for marital status and race run in the opposite direction as in chapter three and in previous research, and likely result from the biased sample.

The models in columns 2 and 3 make better use of the present survey's data and result in improved model fit. Household income becomes the main indicator of financial need, as this survey allowed for more variation in the upper half of the income distribution and considered only those household members that helped support the

respondent. Educational categories are condensed to indicate whether a respondent has had at least some college education. Pregnancy intention is added to the model. A more direct indicator of women's orientations toward abortion and motherhood replaces church attendance: a factor score composed of the woman's identification as pro-choice, pro-life, or undecided; a respondent's assessment of whether the most important people in her life would approve, disapprove, or divide over her decision (coded so that higher values indicate a social network's support for birth); and church attendance. Column 3 includes a dichotomous variable reflecting a respondent's report that she had been receiving help from at least one public assistance program at the time of her pregnancy. Measuring welfare participation in this fashion reduces concerns about the extra assistance eligibility that comes with having an infant.

These models continue to weigh against an economic need explanation for women's abortion decisions. To the extent that economics factor into the decision, the opportunity cost aspect of economics appears much more important than financial need. Income positively predicts the choice of abortion, as does a woman's status as a current employee or student. Controlling for these and the other covariates in the model, women receiving help from at least one welfare program when they found out they were pregnant appear less likely to resolve that pregnancy in abortion, and this coefficient approaches statistical significance (p=.103, two-tailed). This finding is consistent with the theory that welfare programs build the capacity of low-income women to choose childbirth, but should again be read very cautiously in light of the sample's composition.

By far the most important predictor of respondents' childbearing decisions is the orientation of the woman and her social support system toward abortion versus

motherhood. Pro-life women who regularly attend church and whose closest acquaintances support the decision to deliver and raise a child are, not surprisingly, substantially less likely to choose abortion than any other women. Though not shown, when a woman's own opinion toward legal abortion and her close acquaintances' degree of support for her decision are entered into the model on their own, support from the woman's social network explains much more of the variation in pregnancy outcome than does the woman's own identification as pro-choice, pro-life, or undecided.

5.2.2 Financial Need: A Problem and a Priority?

Next I attempt to go beyond the strictly correlational findings on economics and abortion and investigate respondents' perceptions of their economic preparedness for childrearing. Compared to low-income women choosing abortion, I expect that women choosing childbirth will report fewer unmet economic needs and will consider financial need to be less important of a concern. In line with previous research, I expect women to identify multiple abortion reasons or pregnancy concerns, but going beyond this research, I expect the number of reasons that accompany financial concerns to decline as a respondent's disadvantage increases.

Table 5.3 compares the subjective economic situations of mothers of infants, abortion patients, and lower-income abortion patients. The survey measured women's economic assessments and the degree to which these were priorities in several ways. One involved respondents' ratings of the importance of items on a list of reasons believed to incline women toward abortion. Abortion patients were asked if each was a very important, somewhat important, or not important reason for their decision, or if the circumstance did not apply to them. The childbirth group was given the same response

Table 5.3 Financial Factors and Concerns in Women's Childbearing Decisions

	Childbirth Sample	Abortion Sample	Abortion Sample (Low-Income)
Reasons for abortion/concerns during pregnancy			
Struggles to afford basic needs "very important"	31.1	31.8	47.6
Struggles to afford basic needs or inability to afford child despite basic needs "very important" or "somewhat important"	71.1	61.9	73.8
Interference with career/career plans or school/school plans "very important"	24.4	36.5	45.2*
Interference with career/career plans or school/school plans "very important" or "somewhat important"	37.8	55.6*	61.9**
Reasons abortion chosen/thought about			
Welfare rules	8.9	6.4	9.5
Unaware of where to get help affording child	15.6	19.1	23.8
Lack of affordable, reliable care for other children	26.7	11.1**	16.7
Employer or school not supportive of pregnant women and mothers	13.3	1.6**	2.4*
Reasons parenting chosen			
Public economic assistance "very important"	48.9	--	--
Private economic assistance "very important"	59.1	--	--
Other economic issues			
Average number of parental needs	5.1	5.7	5.8**
Percent needs met	69.0	68.4	65.1

Table reports percentages of each sample offering a given response, unless stated otherwise. Abortion sample (low-income) refers to abortion patients reporting annual household incomes of $55,000 (approximately Maryland median household income) or less. Significance tests are from Fisher's exact tests of hypothesis that proportion reporting yes is independent of pregnancy outcome, with exception of "other economic issues" where t-tests are employed: *p<.10. **p<.05 (two-tailed, each relative to childbirth sample).

options and asked to rate the extent to which these circumstances were concerns to them during their pregnancy. Two options tap economic need: "I cannot afford to have a baby because I struggle to afford my own and my family's basic needs" and the more moderate "I can afford my own and my family's basic needs, but I cannot afford to have a baby." The list was based off of the questions in two Alan Guttmacher Institute studies (Finer et al. 2005; Torres and Forrest 1988), with some minor clarifying modifications.

Despite the collectively lower income of the childbirth group and their generally larger families, it is striking that new mothers and abortion patients are equally likely to consider their struggles to afford basic needs as “very important.” This option was selected by 31 percent of the childbirth group and 32 percent of the abortion group. These findings hold even when the sample is narrowed to women with unplanned pregnancies (not shown).

The most expansive definition of financial need also fails to produce a significant difference between the samples. Seventy-one percent of the childbirth group and sixty-two percent of the abortion group named at least one of the two economic need statements as “very important” or “somewhat important.” This gap closes almost entirely when the sample is narrowed only to women who had not planned to be pregnant.

These equivalent proportions may reflect a lower priority that these mothers of infants assigned to financial considerations, but they may also reflect a lower threshold set by these women for what they consider their basic needs or their ability to afford them. In the childbirth group, everyone who rates struggles to afford basic needs as a “very important” concern reports an income of less than $25,000 a year, save for two women in the under $40,000 range. Among abortion patients, 25 percent of those identifying their struggles to afford basic needs as very important report annual household incomes between $25,000 and $55,000.

The proportions of women regarding financial need as important come closer to fulfilling the expectations of my hypothesis when I consider only women with household incomes below the state median. Nearly half of abortion patients in the lower half of the income distribution rate struggles to afford their basic needs as very important. This gap

becomes more pronounced among respondents with household incomes of $25,000 or less: 75 percent of these abortion patients cite this reason, compared to 32 percent of low-income women choosing childbirth.

There is some evidence when looking only at the childbirth group that welfare receipt can mitigate the extent to which inability to afford a child is a concern. Though it does not attain statistical significance in such a small sample, 27 percent of women participating in at least one welfare program at the time they were pregnant rated their struggle to afford basic needs as very important, compared with 40 percent of women not receiving welfare assistance. The pattern is just the reverse among abortion patients, however—I find a greater proportion of welfare recipients saying that struggles to afford basic needs are very important, even when narrowing the comparison to women with the lowest household incomes.

How important are these financial concerns compared to other reasons why pregnancy could be a problem? Struggles to afford basic needs rank as the second most commonly named very important concern, following only “I did not want to be a single mother” (chosen by nearly half the sample). Thirty-six percent of the sample selected at least one of the financial need concerns as very important. Regardless of pregnancy outcome, women identified an average of 2.4 “very important” reasons for the abortion/concerns during the pregnancy (out of a possible 13). The financial need reasons were never chosen alone. Women who did name either of the financial need concerns as very important selected an average of five very important reasons or concerns. This suggests that these concerns may have been less important on their own than other concerns.

Financial need does not even appear to hold singular importance at the lower end of the income scale. The mean number of very important reasons identified falls by only 0.25 when considering women with household incomes below 200 percent of the poverty line. This runs contrary to my expectations.

Also germane to social policymaking, especially with regard to child care and leave time, are women's concerns that a baby would interfere with their career or education, or their plans to pursue either of those. These concerns follow closely behind the financial need reasons, as they were selected as very important by just over a fifth of each sample, and 31 percent of the sample together. Yet women who selected one of these response options as very important also tended to identify a greater number of important concerns than did the other respondents, naming 4 and 4.5 very important concerns. Concerns about interruption of a career or education were more important to abortion patients than to women choosing childbirth, especially when narrowing the sample to women with household incomes below the Maryland median. That these work-family or school-family issues are more important to lower-income abortion patients may indicate lower-income women's poorer access to child care and job flexibility, as well as the somewhat greater proportion of students among this group.

Overall, the distribution of reasons, at least among abortion patients for whom comparison figures are available, resembles that found in a larger national study of abortion patients (Finer et al. 2005). Inability to afford a child ranks as the most commonly given reason (very or somewhat important, for comparability) for choosing abortion, though the percentage of women choosing this reason nationally is about 11 points higher. Relationship problems and the desire to avoid single parenthood were

somewhat more common in this sample (58 percent), as were concerns about a baby's interference with work or school (48 and 41 percent), but did not exceed the national proportions by more than 10 percentage points. The preferences for abortion of a husband, partner, or parents appeared considerably more important to my sample (37 percent) than to Guttmacher's national sample, and potential problems with the fetus's health were somewhat more common reasons (21 percent). The surveys agreed on the commonality of the respondent's belief that she was too young to have children (22 percent). Women's own health concerns (8 percent), rape and incest (0 percent), the desire to conceal pregnancy or sexual activity (17 percent), and having all the children one could want or handle (27 percent) are less common concerns in my sample relative to the national study, though the latter discrepancy could be traced to question wording.[26] Considering that financial need is less important to this sample while disruption of work or school is more important, any conclusions I may reach regarding policy corrections to these issues may be understated with regard to financial need and overstated with regard to employment and education.

Women choosing childbirth were presented with an additional battery of questions regarding the importance of various factors in their decision. This was done in order to assess the importance of economic assistance relative to alternative explanations for these women's decisions, some of which divide the pro-life movement when it are challenged to support social welfare. This battery of questions also distinguished between publicly and privately provided assistance. Respondents were asked whether the

[26] On my survey instrument, the reason read "I already have as many children as I want or can handle." The Guttmacher survey read "Have completed my childbearing," and also offered a related item "Have other children or dependents" as a subreason who respondents indicating that a baby would dramatically change their lives.

following reasons were very important, somewhat important, not important, or not applicable to the decision. The economic items of interest are: "I got help affording a baby from a government program like welfare (TANF), food stamps, Medicaid, child care assistance, or housing assistance" and "I got help affording a baby from family, friends, my employer, school or church, or another organization."

Receipt of both governmental and nongovernmental assistance is important to many low-income women's decisions to raise a child, though nongovernmental assistance appears somewhat more important. Of the entire childbirth sample, 48 percent reported that government assistance was "very important" to their decision, while 59 percent reported that nongovernmental assistance was "very important". Government assistance gains importance relative to private assistance when considering only women with unplanned pregnancies, among which 54 percent found government assistance very important and 56 percent found private assistance very important. Sixty-seven percent of women ranked government assistance as "very" or "somewhat" important to their decision, while 80 percent of women ranked private assistance as "very" or "somewhat" important to their decision. A ten percentage-point gap remains when narrowing the group to women with unplanned pregnancies.

How does the role of economic assistance compare to other possible reasons for the decision to parent a child? Respondents ranked an average of 4.5 reasons (out of a possible 9 reasons) as "very important." Economic assistance thus does not stand out alone and occupies a middle place with regard to the percentage of respondents designating that reason as very important to their decision. Greater shares of women ranked seeing an ultrasound image of their baby (75 percent), a belief that motherhood is

very fulfilling (89 percent), a belief that abortion is wrong (66 percent), and the support of some special people (68 percent) as "very important" to their decision. Economic assistance performs better than only receiving counseling from a pregnancy center (45 percent), inability to afford an abortion (5 percent), and living too far from an abortion clinic (0 percent). This pattern remains the same when including those indicating a reason was "somewhat important."

No respondents cited economic assistance reasons in isolation. Respondents naming either of the economic assistance options as very important also checked an average of just over four other very important reasons. The importance of private assistance is also not statistically independent of the importance of public assistance ($p=0.026$ in Fisher's exact test), again suggesting complementarity of the two. Nearly three-quarters of respondents who said that government assistance was very important to their decision also named nongovernmental economic assistance as very important, while 58 percent of those who said that nongovernmental assistance had been very important also said that public assistance had been very important. The total number of very important reasons named in addition to economic assistance increases slightly, rather than decreases, as income decreases.

As expected given that Maryland's abortion policy and supply are relatively liberal, problems accessing abortion existed but were not tremendously important to women's decisions to parent. Six women (14 percent) said that their inability to afford an abortion was "very" or "somewhat" important to their decision to have and raise their baby, while four women (nine percent) said that living too far from a clinic was

"somewhat important" to their decision. Women who identified inability to afford an abortion as very important averaged 2.5 very important reasons for their decision.

For an alternative assessment of women's economic situations, the survey also asked women about their expectations that they would be able to have access to certain resources on a list—health care, housing, baby supplies, child care, several weeks off from work after childbirth, with most of her pay, and the chance to take a break from school and come back later with no penalties such as loss of financial aid. I determined how many of those resources were relevant to each woman given her employment or educational status. In doing so, I also counted the need as applicable if a respondent had not been employed or in school at the time of the survey, but had indicated by her response to the questions about abortion reasons or pregnancy concerns that she had been employed or in school or had plans to be such.[27] I then calculated the percentage of applicable resources that a respondent thought she had access to at the time of her pregnancy.[28]

Despite the lower SES of the childbirth group, there is no difference by pregnancy outcome in the percentage of needed resources that respondents report having access to—mothers of infants report they had expected access to an average of 69 percent of needed resources, while abortion patients reported expected access to 68 percent of needed resources (65 percent among those with incomes below the median). Even when looking at lower-income women then, substantially greater access to resources does not appear to mark those who chose childbirth. Alternatively, it is possible that women who were more

[27] Women who said that a baby's interference with her career or career plans, or school or school plans, was very, somewhat, or not important to their decision were counted. The need was coded as not applicable for women who were not employed or in school and who selected "does not apply to me" for as their rating of job or school concerns.
[28] A "don't know" response was coded as 0.5.

open to childbirth were also more willing to seek out help and more optimistic about the assistance they could receive.

The work-family and school-family resources were those most commonly lacked by women in my sample. Forty percent of women responded that they lacked access to paid leave time from work or penalty-free leave time from school (the rest answered yes, or indicated that they did not know or the issue was not applicable). Thirty percent responded that they did not expect access to child care during work or school. Health care (89 percent) and housing (81 percent) were the resources that women most expected to have at their disposal. In general, slightly greater percentages of abortion patients expect to have access to a given resource, with the one exception of health care. The only somewhat noticeable difference between lower-income abortion patients and the entire abortion provider sample is that the proportion of women expecting access to paid leave time from work is 25 percent smaller (31 percent versus 41 percent).

I also considered that shortcomings in the family support provided by the American government and marketplace may have more directly affected women's decisions about their pregnancies. I asked respondents about four family policy concerns: welfare rules, lack of awareness about where to get help affording a child, difficulty finding affordable, reliable child care, and a lack of support from an employer or school. Abortion patients were asked whether these factors affected their decision, while new mothers were asked whether any of these issues had made them think about having an abortion.

Initially the childbirth sample appears more likely to have been threatened by shortcomings in family support. Forty percent report that at least one of these

circumstances made them contemplate abortion, in comparison with 25 percent of abortion patients who said these affected their decision. This appears to be largely a function of the childbirth group's lower incomes, as this gap is more than halved when abortion patients exceeding the state median income are removed. Maintaining this income constraint, 10 percent of women in each group reported that a welfare rule such as a work requirement, a time limit, or a sanction made them think about getting an abortion or affected their decision to terminate the pregnancy. Fifteen percent of mothers of infants and 24 percent of abortion patients reported that their lack of knowledge about where to get help affording a child played a role in their decision. Twenty-seven percent of new mothers and 17 percent of abortion patients cited an issue with the scarcity of reliable, affordable child care. An employer's or school's lack of support for pregnant women and mothers was not a substantial problem for lower-middle income abortion patients, as it was mentioned by only one woman as a factor in her decision, but it was somewhat more important for 15 percent of the women choosing childbirth.

At bottom, this descriptive analysis shows that economic need is playing a substantial but not a singular role in low-income women's decision to terminate a pregnancy. Low-income women who choose childbirth do not appear to have fewer financial problems and concerns than do low-income women choosing abortion. Instead, the women who have chosen childbirth just appear to have assigned a lower priority to those concerns.

On the other hand, this finding may very well be mediated by the pregnancy center sample's greater reliance on public assistance programs. Prior knowledge about the assistance available from the government may have reduced the number of needs that

these women considered unmet, and also lowered the priority of their financial concerns in their childbearing decisions. Unfortunately I have no measure of prior knowledge of public assistance options, though a larger percentage of abortion patients cite lack of awareness about help affording a child as a reason for their decision than do new mothers as a reason for thinking about abortion. It is also possible that given the longer time horizon and their actual experience with parenting, these respondents may remember having a rosier view about resource accessibility than they actually did when first learning of the pregnancy.

5.3.3 Social Policy and Social Services: How Decisive?

I next tackle the decisiveness of economic assistance more directly, by considering whether women in each group would have made a different decision about their pregnancy in the presence or absence of economic assistance. Women choosing childbirth were asked whether they whether they would have made a different decision had they not received the particular public and private assistance that was given to them during their pregnancy:

> Think about the help you got from government programs, family, friends, or others, with your expenses like baby supplies, child care, health care, housing, and time off from work or school. Do you think you would have had an abortion if you had not received this help?

This question assesses the extent to which the current public and private safety net prevents abortions. Given this broad conception of the safety net, this question poses perhaps a maximally generous assessment of the importance of economic assistance to abortion decision-making.

Women choosing abortion have done so in spite of the current safety net, though one may question whether these women were completely aware of the help that might have been available to them. They are thus asked about the safety net as it could be, and are presented with a description of the types of assistance programs that are available in several European countries:

> Other countries provide a lot of assistance to women and their families that the government, employers, and schools in the U.S. do not provide. These countries give women things like free child care, free health care, money they can use to pay their family's expenses, and the chance to take months or even years off of work with pay after giving birth. Would you have made a different decision about your pregnancy if you could get that kind of help?

This question may thus be thought of as representing the upper limit of the type of impact that a more progressive welfare state could have in reducing abortions. Each question included yes, no, and I don't know response options.

A follow-up question asked women what type of assistance was (or would have been) most important to a childbirth decision. Options presented included health care, housing, child care, money to pay family expenses, leave time, some other help, and "None of it. I would not have made a different decision."

Table 5.4 reports women's responses to the first set of questions, noting the proportions answering "yes" or "I don't know" along a number of economically relevant characteristics.

Table 5.4. Economic Assistance and the Probability of a Different Decision

	Pregnancy Center Sample	Abortion Provider Sample
<u>A different decision?</u>		
Yes	18.2	22.2
Unsure	22.7	33.3
No	59.1	44.4
<u>Percent deciding differently, by characteristic</u>		
Black		
Yes	21.2	43.3***
Unsure	18.2	26.7***
Age < 25 years		
Yes	19.1	30.8***
Unsure	28.6	50.0***
Assistance recipients at survey		
Yes	17.1	53.9**
Unsure	22.0	23.1**
Household income <$25,000		
Yes	19.4	40.0***
Unsure	16.7	45.0***
No college experience		
Yes	17.7	23.8
Unsure	26.5	47.6
Unmarried		
Yes	18.4	24.0
Unsure	23.7	32.0
Abortion opinion conflict		
Yes	16.7	25.0
Unsure	20.8	50.0
Employed or in school		
Yes	12.5	20.0
Unsure	25.0	36.4
Struggles to afford basic needs very important		
Yes	35.7	35.0***
Unsure	21.4	50.0***
Interference with job/school very important		
Yes	27.3	17.4
Unsure	36.4	39.1
Family policy constraint		
Yes	35.3***	56.3***
Unsure	35.3***	31.3***
Half or fewer parental needs met		
Yes	28.6	22.2
Unsure	14.3	38.9

Table reports percentage of each sample providing a given response. Significance tests reported are Fisher's exact tests of the hypothesis the probability of making a different decision is independent of a given characteristic: **p<.05, ***p<.01 (two-tailed). Tests were performed on one 2x3 table for each characteristic.

Despite the coupling of economic assistance with many other reasons for choosing childbirth, the current public-private safety net did appear to make the difference for some women choosing childbirth. Eight women (18 percent) reported that they thought they would have had an abortion had they not received certain assistance. Another 10 women (23 percent) were unsure as to whether they would have made a different decision in the absence of this assistance.

Also in spite of the multiple reasons for their decision, substantial numbers of abortion patients entertained a different decision in light of their hypothetical economic security. That abortion patients were somewhat more willing than new mothers to consider another decision should not be surprising given the more expansive welfare state description with which they were presented. Twenty-two percent of abortion patients indicate that they would have continued the pregnancy had European-style welfare policies been available to them; another thirty-three
percent were unsure if they would have made a different decision. Less than half (44 percent) of abortion patients declared that they would have made the same decision about their pregnancy if that kind of assistance had been available. The proportions increase when considering only abortion patients with annual household incomes below the state median.

Within the childbirth group, there is little variation by socioeconomic characteristics in the proportion of women saying that they would have or might have

made a different decision about their pregnancy had they not received assistance affording a child. This observation could very well reflect the relative homogeneity of the sample toward the disadvantaged end of the socioeconomic scale. The only statistically significant cleavage in the likelihood of this group's making a decision other than parenthood involves women who indicate that at least one shortcoming of American society and social policy had led them to consider abortion. The shortcomings the survey asked women about were welfare rules, such as a time limit, work requirement, or sanction; lack of awareness about where to get help raising a child, inadequate child care, and an unsupportive employer or school. Of women who indicated that at least one of these issues made them think about having an abortion, 35 percent said they might have been a different decision about their pregnancy in the absence of economic assistance, and another 35 percent said they did not know if they would have decided differently. While not statistically different from the distribution of other mothers' responses, noticeably greater proportions of those women indicating that their struggles to afford their basic needs or a baby's interference with their career or education were very important concerns during pregnancy left open the possibility of a different decision.

Among abortion patients, these descriptive statistics suggest a clearer relationship between women's characteristics and circumstances and their perceived likelihood of choosing childbirth under a more progressive welfare regime. The shortcomings of U.S. social policy again show up importantly, as more than half of respondents who said one of these issues played a role in her decision also say that would have made a different decision about the pregnancy with access to more assistance. Another third were not sure about their answer. Financial need also appears in these crosstabulations to strongly

predict the likelihood that a woman would consider a different decision if facing a wider range of assistance options. A combined 85 percent of women with household incomes under $25,000, as with women saying struggles to afford their basic needs were very important to their decision, entertained the possibility of a different decision. Welfare recipients were also significantly more likely than other women to say they would consider a different decision.

Responses are also patterned according to race and age. A significant 43 percent of black abortion patients say that they would have made a different decision about their pregnancy if European-style welfare assistance had been available to them. While there is more uncertainty among this group, younger women are also more likely than respondents aged 25 and older to consider childbirth.

Employment or schooling status and the relative importance of these concerns appears unrelated to the likelihood that a woman would consider a different decision in a more progressive welfare state, despite the prominent role of child care and leave time in this welfare state's description. Educational attainment, defined here as college experience, is statistically independent of the likelihood of deciding differently, though when comparing only college graduates to other abortion patients (not shown) these women are significantly less likely to consider childbirth. Marital status appears unrelated to the likelihood of deciding differently, as does a conflict between a woman's pre-pregnancy abortion opinion and her choice.

Certainly many of the characteristics and circumstances that appear to make abortion patients' decisions sensitive to welfare assistance are related. Table 5.5 presents results of logistic regression models that attempt to disentangle the effects of financial

Table 5.5. Logistic Regression Model of the Probability of a Different Decision

	(1)	(2)
Chose abortion	2.20**	--
	(0.90)	
	9.015	
Black	1.92**	2.94**
	(0.85)	(1.40)
	6.80	18.99
Financially needy	5.46***	6.46**
	(1.75)	(2.59)
	236.26	639.36
Baby's interference with job or school very important	-1.12	-3.33**
	(0.77)	(1.64)
	0.33	0.04
Employed or in school	-1.07	-0.03
	(0.87)	(1.57)
	0.34	0.97
Age	-0.01	-0.13
	(0.07)	(0.14)
	0.99	0.87
College experience	0.73	2.29*
	(0.79)	(1.38)
	2.07	9.89
Opinion conflict	-0.34	-0.10
	(0.68)	(1.18)
	0.71	0.91
Constant	-6.12**	-3.54
	(2.61)	(4.12)
Pseudo R-squared	0.30	0.45
N	102	63

Table reports logit coefficients, with standard errors in parentheses, followed by odds ratios. *p<.10, **p<.05, ***p<.01 (two-tailed). Column 1 includes the entire sample with nonmissing values, while column 2 includes only abortion patients.

need from those of social policy experience, race, age, education, and other factors. These models test the hypotheses, introduced in chapter one, that the childbearing decisions of financially needy women and black women would be most influenced by their access to economic assistance. I consider that race may have an effect independent of financial need in light of the arguments of welfare and feminist historians that American culture and policy devalues and discourages motherhood among blacks more so than whites (Roberts 1999) and also sociologists' suggestions that some racial differences in

childbearing decisions may be explained by the greater dependence of black families than comparable white families on a woman's income (Trent and Powell-Griner 1991).

I represent decision sensitivity with a dichotomous dependent variable equaling 1 if the respondent said she would make a different decision in the presence or absence of certain economic assistance.[29] Because many of my indicators of financial need are correlated, I combined income, welfare receipt at the time of the survey, women's rating of the importance of their struggles to afford basic needs, and the role of social policy shortcomings in women's decisions into one financial need factor, coded to range from 0 to 1.[30] The model also controls for race, age, educational attainment, current employment and schooling, and the importance of a woman's concerns about career or educational disruption. Another variable identifies women whose pre-pregnancy opinions about abortion suggest openness to an alternative choice—i.e. pro-life or undecided women choosing abortion and pro-choice or undecided women choosing childbirth.[31]

Results suggest strong support for the hypothesis that the pregnancy decisions of financially needy women and black women are sensitive to the availability of economic assistance, even after controlling for other potentially overlapping characteristics and circumstances and the presence of a possible conflict between a woman's opinions and her decision. Financial need is the strongest predictor of the probability that a respondent would have made a different decision about her pregnancy in the presence or absence of

[29] Women who did not know if they would make a different decision are coded as 0 during this analysis. I also ran the same models with a dichotomous dependent variable that also coded the "don't know" responses as 1. The general pattern of results held, but with poorer model fit and fewer statistically significant coefficients. Ordered logit was inappropriate because of the small sample size and because it appeared that the assumption of proportional odds was not reasonable.
[30] These four variables all loaded on one factor, with an eigenvalue of 1.96. The analysis was performed using principal components factor analysis.
[31] Initially I also controlled for pregnancy intention. This variable added no explanatory power at all to the model, and also held no bivariate relationship to the dependent variable.

the economic assistance described. A woman's likelihood of considering a different decision increases dramatically with her level of financial need. When setting all other predictors at their means and moving from one standard deviation below the mean financial need score to one standard deviation above that score, the probability of making a different decision increases from 2 percent to 43 percent.[32] Race also exerts an effect on the probability of a different decision that is independent of financial disadvantage. Black women are several times more likely than nonblack women to say they would make a different decision about their pregnancy, and the predicted probability of doing so increases from 5 percent to 25 percent when the respondent is black. Both of these variables remain significant when only abortion patients are considered (column 2).

Though the availability of child care assistance and leave time from work and school should theoretically affect the decision-making of employees and students under the welfare-programs-as-capacity-building hypothesis, this expectation is not borne out by the present analysis. The decisions of employees, students, and women who rated disruption of their career or education as especially important concerns are no more sensitive than other women's to the availability of these or other types of economic assistance. When considering only abortion patients, the rating of job or school disruption as a very important concern was actually significantly associated with a decrease in the likelihood of considering a different decision.

Briefly I consider the effects of other covariates. Any effect of age on the economic sensitivity of pregnancy decisions evaporates in the presence of other controls. Among abortion patients only, college experience predicts higher decision sensitivity. A potential conflict between a woman's abortion opinion and her actual decision does not

[32] All predicted probabilities were computed using Clarify 2.1 (Tomz, Wittenberg, and King 2003).

affect the likelihood that her decision would be affected by economic assistance. As expected, abortion patients are significantly more likely to entertain a different decision in the presence of a European-style welfare state than are mothers of infants in the absence of their American-style assistance.

5.2.4 What Policies Matter?

Immediately following the decision sensitivity question, women were asked about the types of assistance that were or would have been most important to their decision. The version of the question presented to abortion patients read, “If you might have decided differently, what would have been most important for government or others to provide?” Women who had delivered babies were asked, “Of all the help you received (if any) with your child-related expenses, what kind of help was most important to your decision to have your baby instead of an abortion?” As the instructions were not specific, some women checked multiple responses and others selected only one.

The most common response, selected by just under half of the full sample, was “None of it. I would not have decided differently.” The distribution of this response indicates that some aspect of this question or the decision sensitivity question may have been unclear to some respondents. Four women choosing childbirth selected this response in spite of answering “I don’t know” to the question of whether they would have made a different decision absent economic assistance. Eight abortion patients also provided an inconsistent response, including one woman who had stated that she would have made a different decision under the European-style welfare state. Respondents may have interpreted this option to mean that nothing on the list would have been most important to their decision, despite a “some other help” option. A more likely explanation is that in

answering this question, respondents may have been referencing the probability of a different decision in their actual situation, rather than the hypothetical situation raised in the previous question. Finally, the possibility of carelessness and error in responding to this question or the decision sensitivity question cannot be ruled out.

Those cautions aside, respondents professed themselves to be most in need of money to pay for family expenses. The most fungible form of assistance, in present policy terms this might be best thought of as American cash welfare or child tax credits, or the European family allowance. This type of assistance was named among the most important by 33 of the 105 women with nonmissing responses.

Named by 31 respondents, health care followed close behind as a key component of women's capacity to choose childbirth. Child care was mentioned by 21 respondents. Housing, "some other help," and paid time off from work or school were less important, respectively.

There were some differences in how the two groups of women prioritized these resources. Health care was the form of assistance most frequently cited as important by women choosing childbirth. Money came next, followed by housing and "some other help." Resources dealing with the work/family balance were relatively less important for this group of women. In contrast, child care and paid time off from work or school tie with money to pay for family expenses for the resources abortion patients say would have been most important to their making a different decision. Health care follows, while housing and other assistance appear fairly unimportant to abortion patients.

The importance of health care to the decisions of low-income women choosing childbirth suggests that recent proposals to cut Medicaid eligibility and coverage could

have the effect of increasing abortions among disadvantaged women. Meanwhile, these data suggest that policy entrepreneurs seeking to reduce abortions through social welfare policy might most efficiently spend their energy on expanding child care assistance programs to more working families and introducing paid family leave programs. Such programs probably need not be universal in order to achieve their stated aims, as higher income abortion patients are less concerned about a baby's interference with work or school and are more resolute in their pregnancy decisions.

5.3 Conclusion

The social-welfare-as-capacity-building hypothesis fares somewhat better in the present investigation than it did in chapter four. Nontrivial proportions of low-income mothers of infants indicate that governmental and nongovernmental economic assistance made the difference in the choice to deliver and a raise a baby, rather than obtaining an abortion. Substantial proportions of low-income abortion patients also indicate that they would not have decided as they did about their pregnancy if they had enjoyed greater access to a range of economic supports. This contradicts the assumptions of previous research that the multifaceted nature of the abortion decision must preclude any impact from economic intervention (Faria, Barrett, and Goodman 1985; Torres and Forrest 1988). No woman appeared to be choosing abortion solely out of her economic disadvantage, but the size of the American welfare state does appear to contribute to some degree of choice constraint. That many women expected to have made or did not rule out a different decision suggests that once a family has attained a certain level of

economic security, the other concerns with which financial need interacts to contribute to an abortion decision become less important.

Differences in sample composition, the measurement of concepts, and the time at which they are measured likely all contribute to the conflicts between this study and chapter four with regard to the association between welfare receipt and pregnancy resolution. Yet the findings of my study with regard to the welfare state and women's consideration of an alternative decision are not implausible under the scenario offered by the Fragile Families data. Abortion patients here were asked about a hypothetical scenario that Fragile Families respondents did not consider, and it is also possible for existing welfare programs to be key to a small number of women's choice of childbirth in spite of an overall negative effect.

Overall, however, the results reported here hardly provide the kind of compelling evidence that might be required to raise enthusiasm for welfare programs to a new level. Considering the magnitude of the estimated abortion reduction associated with a European-style welfare state—something in the neighborhood of 20 percent among abortion patients who are slightly better off than average—and earlier chapters' evidence of the effectiveness of antiabortion policies and reductions in abortion supply, it is a stretch to believe that large numbers of Americans would be willing to invest money and votes in such a welfare state. Arguably, results presented here may also not go very far in generating additional sympathy for this target group among citizens who disapprove of abortion. Contrary to what choice rhetoric might imply, this study shows that some abortion patients are responding to economic constraints and do not know where they can get help overcoming them. On the other hand, even for those women for whom economic

need was a leading factor in the abortion decision, lifestyle choices and worldview mattered as well. At the same time, a more objectively disadvantaged group of women appeared still more resolute in the choice of childbirth.

Chapter 6: A Geographic Perspective on Service Accessibility

Thus far I have made several references to access as a particularly important predictor of potential clients' utilization of services. "Access" is a broad concept and barriers to access can take several forms. To this point I have focused mainly on economic, sociological, and legal barriers to women's ability to access social services for parents as well as pregnancy termination services. This dissertation has provided some evidence indicating that as barriers to accessing one set of these services increases, the potential for choosing the pregnancy outcome those services support decreases. In this chapter, I consider that argument again in the context of another potential barrier to service access, geographic barriers. The theoretical rationale behind this investigation involves the sensitivity of service usage to the travel and information costs associated with distance. The relative accessibility of childbirth-supporting services and pregnancy termination services thus should affect the relative attractiveness of these options, especially among women whose more limited means may also signal limited mobility.

I find that access to childbirth-supporting services is somewhat poorer in disadvantaged neighborhoods. On the other hand, there is not such a stark contrast in disadvantaged women's geographically accessible choices as these women's higher abortion rates might suggest. Neighborhood disadvantage does not appear to significantly affect the accessibility of abortion services, and the numbers of both types of service providers appear to increase together.

6.1 The Geography Literature

6.1.1 Geographic Accessibility and Service Utilization

The traditional view of service accessibility and service usage is that target populations' usage of a service is inversely related to the travel costs of reaching the facility where services are provided (Kain 1968; White 1979). Researchers typically measure travel costs with the distance between service providers and potential clients, using a point-to-point calculation of distance or a measure of service provider concentration within a particular geographic space.[33] Substantial research has supported a connection between geographic accessibility and service utilization with respect to many services germane to the present study. Abortion rates have been shown to decline as distance to abortion providers increases (Jewell and Brown 2000; Matthews, Ribar, and Wilhelm 1997; Shelton, Brann, and Schulz 1976). Choice of child care type, and to a lesser extent, maternal employment decisions, are linked to child care availability within geographic space (Gordon and Chase-Lansdale 2001), while the timing of prenatal care initiation has also been tied to the density of prenatal clinics (McLafferty and Grady 2004).

Policy makers and analysts have long expressed interest in the extent to which services are accessible to their target populations. Geographic analysis has been employed with increasing frequency to identify communities or groups with significant unmet needs for services as well as potentially unfair or discriminatory patterns in service accessibility. Studies concerning a wide variety of facilities and resources such as public

[33] More sophisticated theoretical and empirical work also incorporates factors like a provider's location relative to individuals' typical routes, proximity of a provider to providers of related services, and impediments such as traffic congestion or the extra distance roads must take to avoid waterways, parks, and other topographic barriers. Consideration of these issues is beyond the scope of the present study.

schools (Talen 2001), preschools and day care providers (Fuller and Liang 1996; Queralt and Witte 1998), health care providers (McLafferty and Grady 2004), and other municipal services (Hodge and Gattrell 1976; McLafferty 1982) have considered whether patterns can be identified in the accessibility of these services with respect to suspect classifications like a community's racial composition or poverty status, as well as urbanicity or the concentration of other target populations.

In the social sciences, research on service accessibility and its relationship to community characteristics has been perhaps most rigorously applied and debated in the area of the employment of racial minorities. John Kain's "spatial mismatch hypothesis" stated that much black unemployment could be explained by the shifting of jobs from the inner cities, where blacks were concentrated, to the suburbs, where many blacks could not reside because of segregation in the housing market (Kain 1968). The idea that the spatial accessibility of jobs affects the employment levels of a variety of groups remains hotly debated today, with one reviewer arguing that the lack of consensus on this issue results largely from methodological choice and how certain methods are biased in favor of null findings (Houston 2005). Studies employing modern geographic information systems (GIS) technology of the type used in this chapter also disagree, with some supporting the spatial mismatch hypothesis (e.g., Raphael 1998; Stoll 1998) and others finding a minimal or nonexistent role for geographic accessibility (e.g., Cohn and Fossett 1996).

The implication of this research for the study of policy compliance is that a social group's likelihood of engaging in a particular behavior may not be explained entirely by the preferences of individuals belonging to that group. As William Julius Wilson and

others have argued, conservative attempts to define social issues such as minority underemployment and welfare dependency in terms of deficiencies in these groups' moral values miss how structural factors—including spatial structure—constrain individual choices (Wilson 1987). The spatial distribution of services and opportunities can arise from numerous sources beyond the control of the individual, whether markets, governments, and other forces that allocate services in space, as well as constraints arising from the landscape or the development of a city's layout over history (McLafferty 1982). Meanwhile, the motivations attributed to classes of individuals factor into the social construction of these target groups, a concept that some scholars believe affects the type of public policy directed at these groups as well as the nature of these groups' subsequent interaction with the political system (Schneider and Ingram 1993).

To what extent does spatial service accessibility affect women's pregnancy decision-making? While the research cited above has indicated that utilization of abortion and child care are sensitive to the availability of these services in space, we do not know whether their *relative* availability relates to pregnancy resolutions. The data available do not enable a direct test of whether the distance between women's locations and provider locations influences individual decision-making. We can, however, investigate the relative accessibility of abortion services and childbirth-supporting services in the neighborhoods of those groups of women with the highest abortion rates.

We already know that historically disadvantaged groups such as poor women and nonwhite women are over-represented among abortion patients (Jones, Darroch, and Henshaw 2002). Evidence in earlier chapters of this dissertation indicates that nontrivial numbers of women would have made different pregnancy decisions had they been able

(or unable) to access particular economic assistance and social services, and that black women and financially stressed women are the most likely to report such a constraint on their decision-making. A finding that these women's communities are underserved by industries supporting abortion alternatives could suggest that this is part of the puzzle, and that abortion rates might be lowered among these groups by such relatively uncontroversial means as government efforts to boost the supply of child care and other services in their neighborhoods. Such an inference about this issue and the spatial accessibility argument more generally also calls for analysis of the accessibility of pregnancy termination services. I thus examine whether abortion services are simultaneously more accessible in disadvantaged communities relative to better-off communities, or if residents of disadvantaged communities simply have fewer options in *both* service providers.

6.2.2 The Geography of Child Care and Abortion Services

We are only beginning to learn about geographic patterns in child care availability and their relationship to neighborhood characteristics, a task that has been facilitated by the recent emergence of GIS technology as a tool in social science research. The relationship between child care availability and income varies by unit of analysis, metropolitan status, and type of care. One study found lower preschool availability in lower-income counties. It suggested that state child care policy could mediate this relationship, as lower-income communities did not appear so underserved in the study's analysis of one state—Massachusetts—that had explicitly aimed to increase child care availability in these communities (Fuller and Liang 1996). Another study found that child care availability varied by local income levels in nonmetropolitan communities, but less

so to not-at-all in metropolitan areas. Meanwhile, unmet need for child care appeared to be higher in nonmetropolitan areas when considering center-based care, but lower in these areas when considering family day care homes (Gordon and Chase-Lansdale 2001). Moving to a lower level of aggregation that may more accurately reflect the geographic space in which parents search for child care, another study of Massachusetts did find a shorter supply of licensed child care in low-income neighborhoods. The income gap in supply narrowed considerably but did not disappear when considering licensed family homes rather than child care centers (Queralt and Witte 1998). Some limited evidence suggests a nonlinear relationship between child care availability and income, at least with respect to preschools in Massachusetts zip codes (Fuller and Liang 1996) and family day care providers in metropolitan areas (Gordon and Chase-Lansdale 2001). In these studies, working and middle class communities were the least well-supplied. At least one other geographic research effort has produced null findings on income and child care supply (Fronstin and Wissoker 1994, cited in Hofferth 1999).

This new line of geographic research on SES and child care availability thus leaves us without clear expectations for the present study. On the other hand, recent survey research does show that low-income parents perceive less formal child care availability in their neighborhoods than do higher-income parents (Hofferth 1999). Lower-income parents are also less likely to use formal child care, regardless of employment status (Ehrle, Adams, and Tout 2001), which may speak to local shortages as well as issues like cost and preferences.

Researchers have devoted less study to patterns in the locations of abortion providers. One reason may involve the difficulty of obtaining data on these locations. The

Alan Guttmacher Institute maintains the only known, comprehensive database of abortion providers and does not make it publicly available. A major professional association of abortion providers, the National Abortion Federation, also does not share its provider directory. While abortion clinic locations can be compiled piecemeal by researchers willing to expend the effort, I observed that several individual clinics did not list a street address on their websites, claiming that this was for the security of their patients and employees. Given those limitations, the only fairly well-established correlates of abortion provider location are that providers concentrate in metropolitan areas (Finer and Henshaw 2003) and are more plentiful in states with Medicaid funding of abortion services and fewer legal limitations on the procedure (Finer and Henshaw 2003; Hansen 1980; Wetstein 1996).

While no scholarly research appears to have examined the relationship between community socioeconomic characteristics and the availability of abortion services, some limited evidence suggests a hypothesis that abortion clinics may be more likely to locate in low-SES communities. Some pro-life activists, for example, have charged that abortion clinics tend to locate in black, low-income communities. They point to anecdotal evidence as well as one analysis showing that the cities with Planned Parenthood abortion clinics have higher black populations than the states in which they are situated (Hall 2005). Alone, this latter finding may not be all that surprising or controversial given that we might expect facilities serving a larger geographic area to locate in cities rather than in outlying areas, and cities do tend to have larger shares of minority and low-income residents than other areas. Older research on travel cost sensitivity also indirectly suggests that abortion services may be more accessible in minority or low-income

communities. Though this research finds that abortion rates are most sensitive to travel costs among black women, especially black teenagers, and least sensitive among college-age women and women in counties with college campuses (presumed to be students) (Shelton, Brann, and Schulz 1976), black women's abortion rates tend to be higher than those of most other demographic groups (Jones, Darroch, and Henshaw 2002).

Political considerations may also suggest a greater likelihood of abortion provider locations in socioeconomically disadvantaged neighborhoods. Active political opposition in some communities has deterred or prevented the opening of abortion clinics in some areas believed to be underserved (Finer and Henshaw 2003). News coverage of the political and legal battles surrounding proposed clinic openings often cites neighbors' and cities' concerns about how clinics' physical appearance and their likelihood of attracting protestors could lower local property values (e.g., Kaiser Daily Reports 2001; Statvitski 2004). Residents of better-off neighborhoods may perceive a greater fiduciary stake in the opening of an abortion clinic and more likely possess the political and economic resources to initiate and sustain opposition. Thus abortion providers may be more likely to open offices in lower-SES neighborhoods instead, where self-interest as well as a resource-based theory of political participation (Verba, Schlozman, and Brady 1995) predicts less organized resistance to a clinic's opening.

This research thus proceeds with the hypotheses that the geographic accessibility of child care providers will be lower in the neighborhoods of disadvantaged populations relative to better-off populations, while abortion services will be more geographically accessible in disadvantaged communities.

6.2 Data and Methods

For this analysis, I choose one representative of abortion alternatives, child care, which has emerged as a recurring theme in the study thus far. I measure neighborhoods' child care accessibility with the number of state-licensed or state-registered child care providers per census tract.[34] Analysis of child care accessibility is limited to the 12 states for which I was able to obtain a full statewide list of day care providers online or in response to e-mail inquiries, with complete street addresses, free of charge.[35] These states are Alabama, Alaska, Colorado, Iowa, Maryland, Massachusetts, Mississippi, North Carolina, Pennsylvania, South Carolina, Texas, and Washington. Their directories contained a total of 95,624 licensed or registered day care providers.

I compiled a list of abortion clinics locations using several sources: the National Coalition of Abortion Providers online provider directory, a clinic listing at www.abortionclinicpages.com, listings in online yellow pages under abortion clinics, and the clinic locators on the websites of the Planned Parenthood Federation of American and individual Planned Parenthood affiliates. According to the Alan Guttmacher Institute, there were 447 abortion clinics and 386 abortion-performing other clinics in 2000.[36] These clinics accounted for 93 percent of all abortions being performed in the United

[34] The vast majority of child care providers in my data are state-licensed. I also include, however, those providers lacking a full license that are listed on the statewide child care provider registers that are made available to parents seeking child care. These latter providers consist mostly of faith-based day care centers (which in some states are not bound by the same licensing requirements as secular providers) and family homes where the operator did not obtain a license but did accept state child care subsidies as payment.

[35] The one exception to the "free of charge" rule was Maryland, for whose list I paid a nominal fee given the special attention this study has paid to that state. A few other states not included made their full list available, but not in a format that could be imported into a spreadsheet or database. A few other states offered online searchable databases of day care providers, but either strictly limited the number of results that a search could produce or did not provide street addresses.

[36] AGI classifies a provider as an "abortion clinic" rather than "other clinic" if at least half of clinic patients are abortion patients. AGI classifies physician's offices that perform more than 400 abortions annually as abortion clinics.

States (Finer and Henshaw 2003), so focusing only on clinics rather than attempting to locate hospitals and individual physicians that perform abortions is a sufficient way of capturing where most women look when they desire to terminate a pregnancy. My search, conducted in 2005, resulted in a list of 842 providers of abortion services. Since this figure is slightly higher than the Guttmacher figure and the trend in abortion provider numbers has been downward rather than upward, this list likely includes some physician offices or hospital outpatient facilities that may not have been coded as clinics under AGI's definition.[37]

Using GIS software and providers' street addresses, I assigned each provider to a census tract. This was successfully accomplished for 94 percent of child care providers and 99 percent of abortion providers. I use census tracts as the units of analysis because they are believed to best represent neighborhood characteristics as well as the size of the geographic market in which parents typically search for child care (Queralt and Witte 1998). I then merged counts of the number of child care and abortion providers per tract with Census 2000 tract-level data on a variety of demographic, socioeconomic, and geographic characteristics that might predict the location and number of each type of service provider.

Perhaps the most obvious predictor of child care supply is child care demand.[38] I measure neighborhoods' demand for child care providers with neighborhood population size, the proportion of the population of the neighborhood consisting of children under 6, the proportion of the population residing in family households, and the extent of local

[37] I did not attempt to remove these from the database since it would have been nearly impossible to distinguish from the provider name alone whether the provider was officially a "clinic."
[38] Naturally we might expect an endogenous relationship between child care supply and demand, but this is not relevant to the study at hand.

labor force participation. I represent this latter concept with a principal components factor score of the respective proportions of women and men over age 16 who worked in 1999, and the respective proportions of women and men over age 16 working full-time (35 or more hours per week).[39]

Another indicator of the presence of potential child care customers and potential child care employers within a reasonable geographic space is a neighborhood's metropolitan status. Again using GIS, I located the centroid of each tract within Census boundary files and coded each tract as falling within a central city, suburb, or rural area. I also include a measure of population density, and interact this with rural area status in order to capture the greater numbers of providers expected in small towns and other rural population pockets. A measure of neighborhood proximity to interstate highways (dichotomous variable indicating whether the tract centroid falls within one mile of an interstate highway) captures the potential accessibility of a location to clients, though this should be important much more so for child care centers than for family day care homes.

I also attempt to account for high-growth areas. Though these newly developed or otherwise booming neighborhoods might be expected to be particularly attractive to families with children, there may be some lag time before the service provider population catches up to these population movements, and before GIS software recognizes these neighborhoods. In that case, census tracts that have undergone significant population change may appear to have fewer child care providers than their other characteristics would predict.[40]

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[39] These four measures formed one distinct factor, with an eigenvalue of 3.11.
[40] A simple population growth measure over 1990-2000 could not be constructed at the census tract level because between censuses, thousands of tract numbers changed due to splits, merges, and other redrawings of boundaries. Instead, I employ a Census Bureau indicator of whether a tract underwent significant

Models also control for median housing values—which via higher property costs may discourage the decision to use land and structures for child care rather more financially attractive alternatives. It may also indicate local zoning codes that may make it more difficult to run a child care business from one's home. Neighborhood stability—which I measure by averaging the proportion of housing units occupied by owners rather than renters and the proportion of housing units in which the resident has lived for five years or more—may also depress the child care market since residents' social ties may facilitate informal child care arrangements (Queralt and Witte 1998).

I include dummy variables for each state, using Texas as the reference group, in order to capture state-specific variation that may affect the number of providers listed. The number of providers appearing on state lists, for example, may be affected by the stringency of state licensing standards or the state's offering of a "registration" rather than licensure option and the inclusion of these providers in its official child care directories. It also may be affected by state policy and public awareness campaigns aimed at increasing the availability and affordability of child care.

My model considers child care accessibility with respect to three historically disadvantaged groups: the poor, racial and ethnic minorities, and recent immigrants. Similar to a recent study examining child care availability in one state (Queralt and Witte 1998), I form several measures of neighborhood socioeconomic characteristics into one measure of overall socioeconomic distress. A neighborhood scores higher on the socioeconomic distress measure with decreases in median income and the proportion of adult women with at least some college experience. It also scores higher with increases in

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population changes. The Census Bureau codes as having experienced a significant change those Census 2000 tracts that had less than 97.5 percent of their populations in a 1990 tract with the same number.

female unemployment, the proportion of households that are female-headed households with children, the share of the population earning incomes below the poverty line or receiving public assistance, and the proportion of housing units that are vacant. Though the nonwhite and noncitizen shares of a population are positively correlated with neighborhood distress (ρ=.59 and .18, respectively), I retain these as individual predictors in order to detect any patterns in these groups' child care accessibility that may be independent of socioeconomic status.

The model predicting abortion provider location includes a subset of these variables as well as some distinct predictors, as theoretically appropriate. I control for the size of these providers' likely clientele, measured with the number of reproductive-age women residing in a census tract, as well as the share of college students. This is a population whose age range overlaps with those age groups with the highest abortion rates. College students' culturally liberal attitudes as well as the high opportunity cost that would accompany parenthood for them should make them more likely to resolve an unintended pregnancy with abortion. These factors, combined with the residential transience of this population, make it quite unlikely that neighborhoods populated by college students would or could initiate and sustain a lengthy campaign to keep an abortion clinic from locating in town.

The model expects that clinics will locate themselves in more accessible areas, geographically as well as legally. It controls for the presence of an interstate highway within one mile of the centroid of each census tract and also expects that clinics will be more likely to locate themselves in central cities, and to a lesser extent in suburbs, than in rural areas. I also consider interstate variation in abortion policy, measured with one of

five letter grades assigned to states for 2005 by NARAL Pro-Choice America (NARAL Pro-Choice America Foundation 2005). Abortion providers should be more likely to operate within the neighborhoods of states that have fewer legal limitations on abortion access. I also include the same neighborhood stability measure used in the child care provider analysis, also expecting a negative relationship. Long-tenured residents and higher percentages of homeowners likely signal a neighborhood's residential character. As we might expect of other medical offices or places of business that are interested in visibility and accessibility for their clients, abortion providers most likely set up their offices in more commercial districts instead. Local zoning laws may prohibit medical or surgical facilities in heavily residential neighborhoods, and where this is not the case, the threat of NIMBY-type objections from long-tenured homeowners may also deter clinic openings.

Again I consider the homes of three disadvantaged populations in my model of geographic abortion access: neighborhoods high in socioeconomic distress, neighborhoods with high proportions of nonwhites, and neighborhoods with high proportions of noncitizens.

My dependent variables are count variables, ranging in these 12 states from 0-56 for child care providers and 0-2 for abortion providers. Given severe overdispersion in the mean number of abortion providers, I employ negative binomial rather than Poisson regression, and do so in both models for consistency. Another methodological concern involves the possibility of spatial autocorrelation within these geographic data. This was not a problem in models of the abortion provider count, as Moran's I never exceeded |0.04|. Though reduced substantially by the regressors, spatial autocorrelation did remain

noticeable for many states in my analysis of child care supply. For this reason, child care provider models also include a first-order spatial lag of the dependent variable.[41]

The analysis proceeds in several steps. First, I illustrate descriptive patterns in the numbers of child care providers and abortion providers relative to select neighborhood characteristics. Next, I present the results of statistical models predicting the number of child care providers per census tract. With these models, I attempt to discern how the accessibility of these services relates to neighborhoods' relative disadvantage. Finally, I present the results of statistical models predicting the number of abortion providers per census tract, considering how this figure relates to neighborhoods' socioeconomic distress and to the local availability of child care.

6.3 Results

6.3.1 Patterns in Provider Locations

Table 6.1 shows the mean number of child care and abortion providers per census tract by select community characteristics. For neighborhoods at the bottom third of the income distribution, child care providers are at their lowest while abortion providers are at their highest. The number of child care providers per census tract increases steadily as we move to the middle and highest thirds of the income distribution. Meanwhile, the mean number of abortion providers does not change monotonically. Neighborhoods in the middle third of the income distribution house half as many abortion providers per census tract as the bottom third, and this average increases slightly when considering the upper third. When measuring neighborhoods' disadvantage with the broader indicator of

[41] Moran I ranges from –1, 1, where 0 indicates no spatial autocorrelation. Estimation of this statistic and computation of the spatially lagged dependent variable were conducted using GeoDa (Anselin 2004).

Table 6.1 Number of Child Care and Abortion Providers per Tract, By Community Characteristics

	Bottom Third	Middle Third	Top Third
Median HH Income			
Child care providers	4.034*	5.285	6.140#
Abortion providers	0.016*	0.008	0.010
Socioeconomic Distress			
Child care providers	5.842*	5.268	4.375#
Abortion providers	0.010	0.011	0.012
Proportion Nonwhite			
Child care providers	4.731*	5.178	5.578#
Abortion providers	0.004*	0.014	0.016
Proportion College Students			
Child care providers	3.793*	5.596	6.099#
Abortion providers	0.005	0.005	0.025#
Residential Stability			
Child care providers	5.520*	5.786	4.143#
Abortion providers	0.027*	0.004	0.003
Proportion Women in Labor Force			
Child care providers			
Abortion providers	3.157*	5.138	7.253#
	0.011	0.009	0.014#
NARAL Grade (D/F, C, A)			
Child care providers	3.516*	11.782	7.497#
Abortion providers	0.010	0.010	0.021#

*Bottom third is significantly different from middle third at p<.05 (two-tailed).
#Top third is significantly different from middle third at p<.05 (two-tailed).

socioeconomic distress, the worst-off communities continue to have significantly fewer child care providers than the better-off communities. Meanwhile, no significant differences exist in the mean number of abortion providers per tract. Though the share of the nonwhite population is closely related to a neighborhood's socioeconomic circumstances, the same pattern does not obtain in the locations of child care and abortion providers. The number of child care providers per census tract increases with the percentage of the nonwhite population, perhaps reflecting the greater usage of family day care homes—rather than higher-capacity centers—by minority families. The number of abortion providers is significantly lower in those census tracts where racial and ethnic

minorities are most scarce, but does not increase significantly between communities in the middle and top thirds for their nonwhite population.

Not unexpectedly, the number of child care providers per neighborhood increases substantially with the percentage of women in the labor force. There are also more abortion providers per tract in the neighborhoods with the highest percentages of women in the labor force, but the difference is not especially stark. The number of abortion providers per neighborhood, however, increases fivefold when comparing communities in the lower and middle thirds for college student population to communities in the highest third for college student population. Less expectedly, the number of child care providers also increases with the percentage of college students in a community, but this may reflect the simultaneous presence of many working, and perhaps higher-income, women in communities close to colleges.

As expected, those neighborhoods most populated with long-tenured homeowners have fewer child care providers than others, while communities in the bottom third for residential stability have nearly seven times more abortion providers as those in the middle third. Reproductive rights policy is also significantly related to the number of providers per neighborhood, as neighborhoods in states earning "A" grades from NARAL Pro-Choice America have more than double the number of providers as neighborhoods in states earning lower grades. If we understand abortion policy as a proxy for more general social policy liberalism or even the political liberalism of state residents (Erikson, Wright, and McIver 1993), the positive relationship between this indicator and child care supply also makes sense. States with more pro-choice policies have more child care providers per neighborhood, though this relationship is nonlinear, peaking in the middle

third, or states earning "C" grades from NARAL. This could be a fluke resulting from these states' decisions about child care licensing and registration and which types of providers are included on statewide provider lists. It could also reflect several factors that would be difficult to disentangle in a dataset of 12 states, such as subsidy amounts, eligibility thresholds, and recruitment effort, or any link between liberal attitudes and demand for child care.

These select community characteristics are intercorrelated. Residential stability is negatively correlated with the percentage of college students (ρ=-0.38), for example, and the minority population is correlated with socioeconomic distress (ρ=0.59). I attempt to address these relationships in the following section.

Figure 6.1 visually depicts the relationship between neighborhood socioeconomic disadvantage and provider locations for one state, Maryland. The top map shows census tracts by their number of child care providers. The bottom map plots socioeconomic distress by census tract. Given their small number relative to child care providers, abortion provider locations are pin-mapped on this same graphic. On these maps, the darkest shade colors the most economically distressed third of Maryland census tracts as well as census tracts falling in the bottom third for their number of child care providers. While the most economically distressed third of Maryland census tracts averages about 2.5 fewer child care providers per neighborhood than do the middle and bottom thirds (7.8 versus 10.4 and 10.3), this relationship is not particularly striking when displayed spatially. While we observe high levels of socioeconomic distress along with lower numbers of child care providers in some neighborhoods in Western Maryland, the lower Eastern Shore, central Baltimore City, and the northeastern border of Washington, DC,

Figure 6.1. Socioeconomic Distress and Service Providers in Maryland

several notable exceptions emerge. Along Maryland's eastern and western borders, several tracts contain large numbers of child care providers in spite of their high levels of socioeconomic distress. Neighborhoods along the northwestern border of Washington, DC and in suburbs north of Baltimore City show lower numbers of child care providers than their relative lack of disadvantage might predict. Additionally, much more obvious spatial patterns exist for socioeconomic disadvantage than for child care provider supply. Given this comparatively more random spatial distribution of child care providers, many tracts with lower numbers of child care providers are not far from tracts with higher numbers of providers.

Poor neighborhoods in Maryland further appear to be neither under-served nor over-served by providers of abortion services. Perhaps the most obvious pattern in abortion provider locations is that they cluster around the Baltimore and Washington, DC metropolitan areas, and are nearly nonexistent in the rural parts of the state. Some providers have indeed located in the most distressed neighborhoods of otherwise better-off patches of the state, especially in those locations that are furthest removed from Baltimore City and Washington, DC. Plenty of counter-examples exist, however, of abortion providers whose offices are settled in more advantaged portions of the state, or that appear to have eschewed the more central but disadvantaged areas of Baltimore and the DC suburbs in favor of neighboring, less distressed census tracts.

6.3.2 Child Care Accessibility at the Neighborhood Level

Table 6.2 displays the results of two negative binomial regression models of the number of child care providers per census tract. The most important predictor of provider quantity is the size of the resident population. Coefficients on most other predictors go in

Table 6.2. Neighborhood-Level Predictors of Number of Child Care Providers

	(1)	(2)
Resident Population (in 000s)	0.175***	0.175***
	(0.003)	(0.003)
	1.191	1.191
Employment	0.396***	0.400***
	(0.110)	(0.110)
	1.487	1.491
Proportion residents under age 6	-0.431	-0.439
	(0.397)	(0.397)
	0.650	0.644
Proportion residents in family	0.681***	0.700***
households	(0.096)	(0.096)
	1.976	2.013
Central city	-0.062***	-0.064***
	(0.015)	(0.015)
	0.934	(0.938)
Rural area	-0.397***	-0.397***
	(0.024)	(0.024)
	0.672	0.673
Population density	-0.001***	-0.001***
	(0.000)	(0.000)
	0.999	0.999
Rural*Population density	0.034***	0.034***
	(0.007)	(0.007)
	1.035	1.035
Significant Change in Tract Population	-0.068***	-0.069***
	(0.013)	(0.013)
	0.934	0.933
Near interstate highway	-0.003	-0.004
	(0.015)	(0.015)
	0.997	0.996
Socioeconomic distress	-0.315*	-0.347*
	(0.190)	(0.190)
	0.730	0.707
Proportion nonwhite	0.686***	0.689***
	(0.033)	(0.033)
	1.986	1.992
Proportion not U.S. citizens	-1.263***	-1.273***
	(0.114)	(0.114)
	0.283	0.280
Median housing value (in 000s)	-0.001***	-0.001***
	(0.000)	(0.000)
	(0.999)	0.999
Neighborhood stability	-0.081	-0.075
	(0.078)	(0.078)
	0.922	0.928
Number abortion providers		-0.210
		(0.138)
		0.810

Number abortion providers*Socioeconomic distress		1.453***
		(0.560)
		4.275
AL	-0.659***	-0.661***
	(0.032)	(0.032)
	0.517	0.517
AK	0.422***	0.416***
	(0.074)	(0.074)
	1.525	1.516
CO	0.475***	0.476***
	(0.025)	(0.025)
	1.608	1.609
IA	1.068***	1.068***
	(0.033)	(0.033)
	2.910	2.909
MD	0.451***	0.450***
	(0.025)	(0.025)
	1.570	1.568
MA	0.630***	0.632***
	(0.024)	(0.024)
	1.878	1.882
MS	-0.479***	-0.477***
	(0.038)	(0.038)
	0.620	0.620
NC	0.063***	0.063***
	(0.022)	(0.022)
	1.065	1.064
PA	-0.904***	-0.906***
	(0.026)	(0.026)
	0.405	0.404
SC	-0.141***	-0.140***
	(0.030)	(0.030)
	0.869	0.870
WA	0.391***	0.390***
	(0.024)	(0.024)
	1.479	1.477
Spatial Lag of Dependent Variable	0.055***	0.054***
	(0.002)	(0.002)
	1.056	1.056
Constant	-0.221*	-0.233*
	(0.130)	(0.130)
Log pseudo-likelihood	-39550.835	-39539.045
Wald χ^2 (df)	23242.02 (27)	23350.71 (29)
Prob > χ^2	0.000	0.000
Pseudo R-squared	0.171	0.171
N	17459	17459

Table displays coefficients from negative binomial regression, robust standard errors in parentheses, and incidence rate ratios. *p<.10, **p<.05, ***p<.01. Dependent variable is number of child care providers per census tract. The reference state is Texas.

the expected direction. The number of child care providers increases significantly with the work commitment of residents, and also with the percentage of residents living in family households. The share of the population that is children aged five and under does not significantly predict the number of child care providers, but this is most likely because of its close association with the proportion living in family households. Fewer child care providers exist in central city neighborhoods and especially in rural neighborhoods, relative to suburban tracts.

The number of child care providers declines as a neighborhood's socioeconomic distress level increases. This coefficient is marginally significant ($p<.10$) in both models,[42] but the relationship between neighborhood disadvantage and child care supply is not so striking in magnitude as it was in the bivariate context. All else being equal, the expected count of child care providers in neighborhoods with the maximum possible distress level (1) falls below the expected count of child care providers in neighborhoods with minimum distress (0) by a factor of about 0.7 in model 1. Increasing shares of the noncitizen population are also associated with a decrease in the expected number of child care providers. Meanwhile, the number of child care providers increases significantly with the nonwhite share of the population.

Column 2 tests for the existence of a relationship between the numbers of providers of abortion and child care services, allowing it to vary by socioeconomic distress. Here, I find little evidence that abortion and child care providers substitute for each other. While the coefficient on the number of abortion providers in a tract is negative, it does not approach statistical significance. This represents the estimated effect

[42] In model 2, the coefficient represents the estimated effect of socioeconomic distress on child care providers when there are no abortion providers, the lowest and modal value.

of abortion providers when socioeconomic distress is at its lowest level, coded as zero. More importantly, as indicated by the coefficient on the interaction of abortion providers and neighborhood distress, the relationship between the numbers of both service providers becomes more positive at increasing levels of socioeconomic distress. Estimates produced by CLARIFY (Tomz, Wittenberg, and King 2003) find no significant change in the predicted quantity of child care providers when abortion providers are increased from zero to their maximum (2) in relatively well-off neighborhoods (one standard deviation below the mean socioeconomic distress level). In neighborhoods at one standard deviation above the mean distress level, however, a change from 0 abortion providers to 2 is associated with a significant *increase* ($p<.01$) of 2.4 child care providers.

6.3.3 Abortion Accessibility at the Neighborhood Level

The negative binomial model of the number of abortion providers also offers little support for the idea of poor neighborhoods as simultaneously under-served by the child care industry and over-served by abortion providers, where "under-served" and "over-served" are interpreted as relative to better-off communities (rather than relative to demand). All else being equal (see table 6.3), a neighborhood's degree of socioeconomic distress appears statistically unrelated to the count of abortion providers in that neighborhood. An increasing share of the nonwhite population also predicts a marginally significant decrease in the number of abortion providers.

Instead, the most important predictors of a neighborhood's abortion provider quantity are metropolitan status, state abortion policy, neighborhood stability, and the proportion of college students. Consistent with previous research, the expected count of abortion providers increases when moving from rural areas to suburbs to central cities.

Table 6.3. Neighborhood-Level Predictors of Number of Abortion Providers

	(1)	(2)
Number reproductive-age women (in 000s)	0.115	-0.075
	(0.123)	(0.125)
	1.121	0.928
Proportion college students	2.052***	-1.036
	(0.480)	(0.704)
	7.785	0.355
Neighborhood stability		-4.698***
		(0.609)
		0.009
Near interstate highway	0.318*	0.286
	(0.181)	(0.178)
	1.375	1.331
Rural area	-1.103***	-0.789**
	(0.359)	(0.371)
	0.332	0.455
Central city	1.181***	0.881***
	(0.179)	(0.182)
	3.257	2.414
Socioeconomic distress	0.309	-0.527
	(1.071)	(1.085)
	1.362	0.590
Proportion nonwhite	-0.438	-0.723*
	(0.320)	(0.370)
	0.646	0.485
Proportion not U.S. citizens	2.779***	1.180
	(0.788)	(1.360)
	16.104	3.255
Abortion policy liberalism	0.274***	0.207***
	(0.055)	(0.058)
	1.316	1.231
Child care providers		0.068**
		(0.027)
		1.071
Child care providers*Socioeconomic distress		-0.163*
		(0.089)
		0.850
Stabilty*proportion college students		5.462***
		(1.571)
		235.617
Stability*proportion not U.S. citizens		-1.720
		(4.158)
		0.179
Constant	-6.089***	-2.903***
	(0.342)	(0.495)
Log pseudo-likelihood	-974.516	-936.080
Wald χ^2 (df)	212.84 (9)	297.32 (14)
Prob > χ^2	0.000	0.000
N	17460	17460

Pseudo R-squared	0.089	0.125

Table displays coefficients from negative binomial regression, robust standard errors in parentheses, and incidence rate ratios. *p<.10, **p<.05, ***p<.01. Dependent variable is number of abortion providers per census tract. The reference state is Texas.

This figure also increases in neighborhoods of states recognized for more liberal abortion policies and politics.

The estimated effect of a neighborhood's stability on the count of abortion providers is substantial, and is closely tied to the tract's share of college students and noncitizens. In neighborhoods without college students and noncitizens, increasing stability predicts a significant decrease in the number of abortion providers. The relationship between neighborhood stability and abortion providers, however, becomes significantly more positive as the proportion of college students increases (and the proportion of noncitizens remains at zero). When neighborhood stability takes the value zero, the share of the college student population is statistically unrelated to the number of abortion providers. Again looking at the coefficient on the interaction of neighborhood stability and the college population, however, with growing stability, an increase in the proportion of college students predicts a significant and substantial increase in the number of abortion providers. Neighborhood stability also mediates model 1's initially eye-catching relationship between a neighborhood's noncitizen population and its number of abortion providers. At increasing levels of community stability (assuming no college students), higher proportions of immigrants cease to predict an increase in abortion providers.

The number of abortion providers increases significantly with the number of child care providers, but the negative coefficient on the interaction of the two indicates that this

relationship tapers off at higher levels of socioeconomic distress. Changes in expected counts can sort out whether the offsetting coefficients of socioeconomic distress (negative), child care providers (positive), and the interaction of the two (negative) reflect any significant change in the expected count of abortion providers. CLARIFY estimates produce null findings. Holding child care providers and all other covariates at their means, increasing socioeconomic distress from one standard deviation below to one standard deviation above the mean produces no significant change in the predicted count of abortion providers. Setting neighborhood distress levels at one standard deviation above the mean (0.32) and also at exceptionally high levels of disadvantage (0.75),[43] increases of various magnitudes in the number of child care providers are also dissociated from any significant change in the expected count of abortion providers.

6.4 Discussion

Taken together, these results offer only slim support for the idea that poor women's higher abortion rates may stem from a failure of the child care industry and public policymakers to see that poor neighborhoods are adequately supplied with child care. Child care providers are more scarce in poor neighborhoods, and government efforts to boost the supply of child care in these locations may indeed enhance poor women's capacity for the reproductive choice of childbearing. If these efforts have any effect on poor women's childbearing decisions, however, this effect may not be overwhelming. The negative relationship between child care supply and socioeconomic disadvantage is of only marginal statistical significance, and it is sensitive to other neighborhood characteristics. These include the presence of abortion providers, or—more likely—

[43] The interaction of the two was adjusted accordingly.

unmeasured neighborhood characteristics that the existence of abortion providers may represent.

Findings with respect to child care supply in minority neighborhoods contradict the idea that abortion rates may be tied to a geographic lack of childbirth-supporting alternatives. While abortion rates are higher among black and Latina women, the number of child care providers actually increases significantly in neighborhoods with higher proportions of nonwhites.

This analysis does not support the idea that poor women have greater geographic access to abortion providers, and thus may find this choice easier to exercise. Abortion providers do not appear more likely to locate in poor neighborhoods relative to better-off neighborhoods. They actually appear less likely to locate in minority neighborhoods. They are, however, more abundant in neighborhoods with higher concentrations of another, more advantaged, clientele: college students.

At the neighborhood level the counts of each set of service providers appear to complement each other, rather than substitute for each other. Both service providers tend to locate in more populous, metropolitan census tracts. The presence of an abortion provider does not appear to crowd out childbirth-supporting alternatives such as child care in the most disadvantaged neighborhoods. It is in such neighborhoods that the positive relationship between both provider counts is at its strongest.

In the end, however, these findings are hardly definitive with respect to the broader question of provider access and childbearing decisions. Models did not include a direct, neighborhood-level measure of birth or abortion rates. Instead, they employed population characteristics associated with those rates.

Certainly one can also imagine that findings could be sensitive to the measurement of provider supply and geographic access. This analysis, for example, does not take provider capacity into consideration. These data were not available for abortion providers, and were available for only some states' child care providers. In this analysis, a day care center serving 100 children counts equally with a family provider caring for only a handful of children. If large, commercial day care centers are less likely to locate in poor neighborhoods than in more advantaged neighborhoods, the marginally significant negative relationship between neighborhood disadvantage and child care providers may understate the true degree to which poor neighborhoods are under-served. Similarly, if the abortion providers in advantaged neighborhoods are more likely to be individual physicians' offices while those in more distressed neighborhoods are more likely to be high-volume clinics, the lack of an observed relationship between neighborhood disadvantage and provider numbers may also obscure reality.

This analysis also employs a relatively crude measure of geographic access to services, in provider counts within a census tract. It does not take into account factors such as actual distance clusters of potential clients must travel, or the ease with which clients could travel from their own neighborhoods to provider locations by car or public transportation. The census tract level also is probably not the ideal level of analysis for the study of abortion provider locations. It was adopted for the present study only in order to make the results comparable to the study of child care providers. Parents traveling to a child care provider may do so on a daily basis, so the distance a woman would be willing to travel for this service will be considerably shorter than the distance she might be willing to travel to obtain one abortion. In this analysis, however, neighborhoods are

treated alike regardless of whether the nearest abortion provider exists in a neighboring census tract, or in a tract 200 miles away.

Keeping those limitations in mind, the findings of this chapter are generally consistent with findings from earlier chapters. Access to one abortion-alternative resource, child care providers, is lower in poor neighborhoods than in better-off neighborhoods, just as access to parental resources such as child care, health care, housing, leave time, and money was significantly poorer among low-income women in my Baltimore area study of abortion and pregnancy center clients. Public policy expanding the resources available to poor mothers could very well decrease abortions, as suggested by state-level and Baltimore-area individual-level evidence. On the other hand, this kind of assistance will be important only for a subset of mothers and mothers-to-be, and will hardly eliminate demand for abortion, even among the poorest women. Just as individual economic resources are only one of many factors involved in childbearing decisions, geographic barriers to abortion alternatives—barriers that governments could conceivably lower—also appear to play a small but not overwhelming role in poor women's demand for abortion.

Chapter 7: A Mass Constituency?

The political question implied by this study of social services and abortion decision-making has been, "Should pro-lifers vote Democrat?" The answer appears to be a resounding "it depends." Below, I summarize an answer to the "should they" question, and proceed to consider in the rest of this chapter, "If so, would they? And is it worth it to the Democrats to pursue their votes?"

Entertainment of the idea that a pro-life American could more effectively promote her pro-life goals by voting for candidates of a pro-choice party depends upon two assumptions. The first assumption I make is that pro-life voters' ultimate goal is to reduce the number of abortions rather than simply outlaw abortion. Some will question this assumption (e.g., Schroedel 2000), though it is not clear to what extent pro-life activists, much less the masses, think of the movement's concrete goals like overturning *Roe v. Wade* and passing a Human Life Amendment as ends in themselves versus means to an end. The second assumption is that pro-life Americans would lean Democratic if they came to believe that Democrats' capacity-building, pro-welfare policy tools, even coupled with a pro-choice stance toward abortion access, would reduce abortions more effectively than Republicans' combination of welfare conservatism and authority or symbolic abortion policy tools.

The present study offers little support for the idea that the Democratic policy combination would more effectively reduce abortions. Given that, pro-life welfare conservatives would appear to have little reason to abandon the Republican party. Pro-life welfare liberals are another story, and it is on this potential constituency that this

chapter will focus. Presumably, these individuals have reasons for supporting the more pro-welfare party that are independent of their abortion attitudes. As discussed in chapters one and two, some political commentators believe that these Americans have become alienated from the Democratic party over abortion and other cultural issues, but that it would take only subtle changes in the Democratic approach to these issues to win or recapture this group's support. Framing effects, for example, can powerfully influence public opinion (e.g., Druckman and Nelson 2003; Jacoby 2000; Nelson, Clawson, and Oxley 1997; Nelson, Oxley, and Clawson 1997), and some Democrats believe they could tip the electoral balance in their favor by reaching out to pro-life Americans, including by reframing social welfare as a pro-life issue. Though pro-life, pro-welfare Americans not provide a wealth of new Democratic votes, Democrats might still be interested in courting them. The two major parties have recently been so competitive that it would not take much mobilization or conversion in order to tilt the balance of power.

We know that those who might be most predisposed to respond to a pro-life frame on welfare issues—individuals holding both a liberal position on social welfare and a conservative position on cultural issues—have in the past made up a sizeable portion of the electorate (Shafer and Claggett 1995), but we do not know if they remain politically relevant. Republican strategy since the 1970s has included attempts to peel culturally conservative voters away from their Democratic roots (McKeegan 1992; Melich 1996). We also have reason to believe that the pool of pro-life, pro-welfare Americans may be shrinking. The well-documented polarization of Democratic and Republican elites and masses over abortion (Adams 1997; Carmines and Woods 2002; Layman and Carsey 1998; Sanbonmatsu 2004) has occurred without a drop in polarization over social welfare

issues (Layman and Carsey 2002). While some of the mass public changed its party identification in response to their most salient issue position, others have been bringing their issue positions into line with their party elites over the 1990s (Carsey and Layman 2006).

In this chapter, I examine the characteristics and political behavior of those Americans combining pro-life and pro-welfare positions.[44] I attempt to gauge the potential for Democratic gains among this group by considering the group's present size, party ties, ideological positioning, and presidential voting. I also consider factors that may influence its future behavior: political awareness, the relative salience of social welfare versus abortion, and the extent of membership in demographic groups believed to be realigning to the GOP.

Though Democratic strategists may see some signs of encouragement in this analysis, the balance of findings suggest that a change in the Democratic message may not yield a major payout among this group. Using the 2004 National Election Study, I estimate that pro-life, pro-welfare individuals constitute about 20 percent of the adult mass public whose positions on both issues are known. Their present political orientations look little different from the rest of America's. They assign greater importance to social welfare than abortion and are also more likely to identify party differences on the former issue, though the members of this group most ripe for receiving and accepting elite cues are also the most supportive of George W. Bush. Respondents belonging to groups believed to be on their way out of the Democratic fold—evangelical

[44] I define pro-life, pro-welfare Americans more specifically later in this chapter. Briefly, this group consists of individuals a) believing that abortion should never be legal or should be legal only in cases of rape, incest, or danger to the life of the mother, and b) supporting public health insurance and federal spending on welfare, child care, and the poor.

Protestants, white Southerners, and to some extent, Catholics—compose much of the pro-life, pro-welfare ranks. The more defining characteristic of this group, however, is the low socioeconomic status of its members. This group also includes a disproportionate share of those who might be most affected by the policies considered in this study—low-income women of reproductive age. Perhaps not surprisingly given their resource deficit, pro-life, pro-welfare Americans exhibit lower levels of political awareness, interest, and participation than the rest of the mass public. Thus even considering the small pool of citizens likely to notice and consider new messages from the Democratic party, their relative disengagement may discourage mobilization efforts. Should these efforts be mounted, however, I suggest that they could bear modest fruit by increasing this group's political participation. This assumes that the participation deficit remaining after accounting for resource disparities is driven at least in part by the lack of elites representing this issue profile.

7.1 Theory and Expectations: Citizens in a Realigning Electorate

There are at least two lenses through which we might view pro-life, pro-welfare Americans and their political behavior, and they yield different but not necessarily conflicting predictions about this group. I focus on group membership, since party coalitions are typically discussed in these terms. Those memberships and each perspective I offer on this issue combination also suggest some expectations about these Americans' political behavior.

7.1.1 A Distinctive Ideology

Through the first lens, we might think of this issue combination as a distinctive and coherent political ideology that has been displaced in the current partisan alignment. One of the more obvious sources of cues for this philosophy may be churches. Some faith traditions, most ostensibly Catholicism, weave a pro-life position on abortion together with support for the welfare state, claiming that respect for the dignity of human life, especially the most vulnerable, may require both positions (Bane and Mead 2003; Perl and McClintock 2001). One recent analysis found that after controlling for fundamentalism, religiosity was simultaneously associated with more conservative positions on cultural issues like abortion and more liberal positions on other issues (Barker and Tinnick 2006).

Additionally, this issue combination had once been commonplace among the Democratic masses, and so may suggest the continuing influence of older elite cues. The major party platforms did not develop and elites did not begin to clearly differentiate their positions on abortion until the 1970s. At that time, Republican mass identifiers were actually recorded to show more support for legal abortion (Adams 1997; Carmines and Woods 2002; Sanbonmatsu 2004; Wolbrecht 2000). Prior to the 1970s, Democrats had staked out a more traditional position on women's rights more generally, while Republicans had expressed a more libertarian perspective (Freeman 1987; Wolbrecht 2000). Older Americans, especially those of retirement age, should thus be more likely to combine pro-life and pro-welfare attitudes. These citizens were politically socialized when the New Deal coalition was in its heyday, before American politics polarized on cultural issues and when majorities of Democrats expressed more traditionalistic views.

Other groups once believed to be part of the older Democratic coalition (Axelrod 1972) may also populate this space between a consistent left and right, in particular union workers and citizens residing in the South or the Rust Belt. In addition to targeting Catholics and evangelicals, Republican strategists starting in the late 1970s aimed at drawing these groups of traditional New Deal Democrats into the GOP fold, by playing on their conservative leanings on abortion (McKeegan 1992; Melich 1996).

Third, the pro-life, pro-welfare stance might be understood as representing group interest. In particular, at least historically, some leaders in the black community have equated abortion with black genocide (Combs and Welch 1982), while one analysis suggested that some whites favor abortion as an alternative to supporting blacks with welfare (Hall and Ferree 1986). Though not necessarily opposed to legal abortion, black feminists over time have linked welfare and reproductive rights, arguing the social welfare is essential to securing black women's right to bear children (Nelson 2003). For the black population more generally, social welfare liberalism is believed to be an expression of group interest (Dawson 1994).

While individuals espousing pro-life, pro-welfare views do not appear to have been specifically studied, literature on various aspects of these issues previews to what extent the groups I have associated with the coherent ideology perspective make up this segment of the public. This research indicates that the above predictions may be slightly off the mark. Theoretically, Catholics should be over-represented among this group, though empirical evidence provides little to no support that Catholic ideology is constrained in such a fashion (Jelen 1990; Perl and McClintock 2001). Previous research on 1980s data suggest that it is actually evangelical Protestants, despite the more

conservative cues on social welfare provided by church leaders, who should make up a notable share of the pro-life, pro-welfare population (Jelen 1990; Shafer and Claggett 1995). This research, however, may be dated and also particular to the indicators employed, "welfare" spending in one study, and a broader economic issues factor score in another. More recently, though evangelicals overwhelmingly express pro-life, culturally conservative views, their social welfare conservatism on a host of welfare policy issues exceeds that of other major religious groups (Layman and Green 2006). Americans who reached adulthood before the 1960s are more pro-life than younger cohorts (Cook, Jelen, and Wilcox 1992; but see Strickler and Danigelis 2002 for different results when age is measured continuously), but on welfare spending specifically, age is associated with increased conservatism (Gilens 1999). Today, blacks remain more pro-life than whites (Jelen and Wilcox 2003) as well as more supportive of the welfare state (Kinder and Winter 2001), and many tend simultaneously toward cultural conservatism and economic liberalism (Shafer and Claggett 1995). While scholarship on Latino group interest is not so well-developed as that concerning black group interest, we do know that Latinos tend to be more pro-life and more supportive of the welfare state than the general population (DeSipio 1996).

Should pro-life, pro-welfare America consist largely of the above groups, Democratic overtures toward any such constituency ultimately might better be characterized as an exercise in retention, more so than mobilization or conversion. Among those groups I have hypothesized for any pro-life, pro-welfare constituency, religious individuals, (white) Southerners and to a lesser extent, Catholics, have been

gradually realigning their loyalties to the Republican party as cultural issues like abortion have become more polarizing (Layman 2001).

7.1.2 The Politically Less Sophisticated

Another possible lens for viewing pro-life, pro-welfare individuals and their behavior is through scholarship on mass belief systems. Since elites have situated abortion on the left-right spectrum, and the masses are increasingly doing so (Adams 1997; Carmines and Woods 2002), individuals' possession of pro-life and pro-welfare beliefs may indicate an inability or unwillingness to engage in ideological thinking. Pro-life, pro-welfare Americans, in other words, may lack political sophistication, a concept incorporating degree of ideological constraint as well as political knowledge and the tendency to actively use ideological concepts in political thinking (Luskin 1987). If this is the case, these individuals become a less lucrative target for Democratic mobilization—they may be harder to locate and may be less likely to receive and respond to political messages. I discuss this in more detail shortly.

The ideological constraint view suggests some pro-life, pro-welfare demography, as well as clear predictions about this group's political behavior. As education ranks among the top predictors of ideological constraint and consistency (Campbell et al. 1960; Converse 1964; Jacoby 1988), a view of pro-life, pro-welfare individuals as politically unsophisticated predicts again a relatively low educational attainment for this group. This view offers discouraging predictions for Democrats (and Republicans) about the profitability of altering messages to attract this group. A lack of ideological constraint is also correlated with lower levels of political knowledge, media exposure, and interest in politics (Berelson, Lazarsfeld, and McPhee 1954; Jacoby 1995; Krosnick and Milburn

1990; Zaller 1990), factors that in turn affect participation as well as the potential that persuasion or framing will bear fruit. The politically uninformed tend to be the politically uninvolved (Campbell et al. 1960; Verba, Schlozman, and Brady 1995). Because of their lower likelihood of exposure to political messages, less informed or less sophisticated individuals are less likely to change their opinions in response to elite cues (Converse 1962; Zaller 1992). The least sophisticated are also less susceptible to elite attempts to change how individuals weigh political considerations through framing, presumably because they fail to cognitively link the frame to their existing considerations or opinions (Druckman and Nelson 2003; Nelson, Oxley, and Clawson 1997).

We should expect a similar pattern of political behavior from pro-life, pro-welfare Americans if we take the related view that the combination of these issue positions may indicate cross-pressures (Berelson, Lazarsfeld, and McPhee 1954), such as between the pro-life (and possibly pro-Republican) cues advanced by one's church and the pro-welfare (and possibly pro-Democratic) cues associated with one's social class, racial, ethnic, or other identifications. Cross-pressured individuals tend to disengage from politics. They show more ambivalence in their issue positions, expose themselves less often to the media, and are more likely to identify as Independents and to decline to vote or show other forms of support for a party or candidate (Berelson, Lazarsfeld, and McPhee 1954; Campbell et al. 1960; Mutz 2002).

Research on the determinants of pro-life attitudes and welfare attitudes suggest that Americans combining these issue positions possess many of the same demographic characteristics typically associated with lower levels of political sophistication and participation. Individuals with lower educational attainment join aforementioned blacks

and “low Protestants” (evangelicals) to dominate the culturally conservative, economically liberal combination of the “two majorities” studied by Shafer and Claggett (1995). More highly educated individuals have always been more pro-choice, though of late this relationship has weakened and appears to be mediated by partisanship and religion (Jelen and Wilcox 2003). Whether income predicts abortion opinion independently of education, religiosity, and traditional worldviews is less clear, but lower-income people are generally believed to be more pro-life (Himmelstein 1986). Income negatively predicts support for equal gender roles, which at best correlates modestly with abortion opinion (Sanbonmatsu 2004). While self-interest does not clearly drive support for the welfare state, lower incomes and related measures of group interests remain important predictors (Bobo and Kluegel 1993; Dawson 1994; Gilens 1996; Kluegel and Smith 1986).

A finding that the pro-life, pro-welfare population indeed leans toward the lower end of the socioeconomic scale carries both good and bad news for the Democrats. Lower-income Americans are increasingly counting themselves among Democratic supporters (Brewer and Stonecash 2001; Stonecash et al. 2000), and because they are doing so, we might assume that this group attaches greater importance to social welfare issues than to abortion. This may more favorably dispose this group toward Democratic voting when redistribution is an issue, if members are not already regularly voting Democrat. On the other hand, any potential for Democrats to increase votes from this group may be depressed by what we know about the participation of such demographic groups. Poorer and less-educated individuals, including disproportionate shares of

nonwhites, exhibit well-established lower levels of political participation (Rosenstone and Hansen 1993; Verba, Schlozman, and Brady 1995).

A pro-life, pro-welfare constituency may have one other distinguishing characteristic that is not clearly implied by either perspective on the coherence of this ideology. Based on the individual literatures on abortion and welfare opinion, we might also expect women to outnumber men in the pro-life, pro-welfare group. While gender holds no consistent relationship with abortion attitudes (Alvarez and Brehm 1995; Fiorina, Abrams, and Pope 2005), women do more strongly support the welfare state than do men (Kaufmann and Petrocik 1999).

In the following pages, I explore the extent to which the predictions of the philosophy/cross-pressures view and the ideological consistency view describe the characteristics and political behavior of pro-life, pro-welfare Americans in 2004. Before proceeding, a final theoretical point concerns who among this group is most likely to remain or to become a more consistent Democratic voter in response to framing welfare as a pro-life issue. Applying Carsey and Layman's (2006) theory of partisan and issue conversion—that individuals' over-time changes in party identification or in issue positions are a function of awareness of party differences on given issues and the salience of those issues—to the study at hand, I assess the relative magnitude of a particular group of pro-life, pro-welfare Americans who might provide the most reliable source of new or continuing Democratic support in response to a revised message. These are people who are aware of party differences on social welfare, and for whom social welfare issues are at least more salient than abortion.

7.2 Defining Pro-Life, Pro-Welfare Americans

I conduct this exploratory study of pro-life, pro-welfare Americans using the 2004 American National Election Study (NES). This study provides a wealth of data on Americans' policy issue positions, political awareness, political participation, and demographic characteristics, including a detailed measure of religious affiliation. As these data represent a single cross-section, any findings are naturally limited to this particular election year and cannot indicate any ongoing trends. Likewise, any predictions made about Democrats' potential gains among pro-life, pro-welfare Americans are based solely in 2004 data and discussions in the extant literature about the type of future behavior that might be expected of individuals possessing certain characteristics.

A number of NES questions gauge respondents' support for social welfare programs. I define "pro-welfare" with respect to only the types of programs considered by the earlier chapters of this study. Four NES questions bear on these programs: a question on respondents' degree of support for a universal public health insurance plan, and the three federal spending questions dealings with child care, welfare programs, and aid to the poor. The appendix contains question wording.

I classify individuals as pro-welfare if they take at least the middle position on all of these questions (a placement of 4 on the 7-point government health insurance scale and the "keep spending the same" position on the spending questions) and additionally come down on the liberal side of at least one of these questions (one of three points on the government health insurance side of that scale or an "increase spending" position). I use the same criteria to also place respondents who answered three of the four questions into

a pro- or anti- social welfare category. By this definition, 476 respondents are classified as "pro-welfare" and 491 respondents are classified as "anti-welfare."

This measure stacks up reasonably well with other ways of identifying "pro-welfare" Americans. My pro-welfare dummy variable is positively correlated (ρ=0.71) with a principal components factor score based on a wider range of welfare questions, my four questions plus three additional scales dealing with support for government-guaranteed jobs and living standards, the balance of government services versus government spending, and support for government aid to blacks. My pro-welfare group's mean scores on those three additional questions are substantially more liberal than the entire sample's. All but 11 percent of individuals in the most liberal third for the broader welfare score are included in my definition. Thirty-six percent of individuals meeting my pro-welfare criteria do not fall in the top third of broader welfare distribution, but their scores are considerably more liberal the entire sample's.[45]

I categorize as "pro-life" those individuals stating that abortion should never be legally permitted, or that abortion should be permitted only in cases of rape, incest, or danger to the life of the mother. Though the 2004 NES includes two other abortion policy questions, concerning support for a ban on partial-birth abortions and support for government funding of abortions, the inclusion of these variables in my definition would be inconsistent with what it means politically to be "pro-life." Unlike social welfare politics, abortion politics at the elite level is very much a matter of absolutes. One is pro-

[45] Considering that my measure relies heavily on spending questions, which respondents might interpret as different issues than the question of government's role in social welfare provision, I also examined the overlap between my definition and another alternative. This was another principal components factor score, but without the three spending questions. This measure correlated at .68 with my pro-welfare dummy. Seventy percent of respondents scoring in the most liberal third on this variable were included in my definition, and vice versa.

life or one is not, and pro-life organizations rely almost exclusively on responses to the question of abortion's legality in bestowing the "pro-life" label. Meanwhile, large segments of the public support limitations on abortion such as the partial-birth abortion ban, while continuing to support the basic concept of legal abortion (Ladd and Bowman 1999). Previous research has also shown that the government funding question reflects respondents' orientation toward social welfare as well as their orientation toward abortion (Legge Jr. 1987), which would further contaminate attempts to identify pro-life, pro-social welfare respondents.

Using these definitions and weighting for the national distribution of age, gender, race, and region, I estimate that 20 percent of the American voting-age population with opinions on both issues fits the pro-life, pro-welfare issue profile. As shown in the first line of Table 7.1, this group of individuals is the smallest of the four groups created by mapping the pro-life/pro-choice divide onto the social welfare divide. The most commonly held issue profile (28 percent) is a pro-choice, pro-welfare combination, closest to the stance of the Democratic party. Viewed another way, 43 percent of pro-life individuals were classified as pro-welfare, while 41 percent of pro-welfare respondents presented a pro-life stance.

7.3 Results

7.3.1 Demographic Characteristics

How demographically distinct is this group of cross-pressured Americans? Table 7.1 compares the four abortion-welfare issue profiles along the proportion of each group possessing a particular demographic characteristic. It notes where pro-life, pro-welfare Americans differ significantly from other pro-life individuals, other pro-welfare

Table 7.1 Demographic Characteristics of Pro-life, Pro-welfare Americans

Percentage	Pro-life/ Pro-welfare	Pro-life/ Anti-welfare	Pro-choice/ Pro-welfare	Pro-choice/ Anti-welfare
Of Total#	.196	.256	.284	.263
Catholic	.259	.256	.279	.208
White Evangelical Protestant	.251	.263	.076***	.149**
Secular	.108	.056	.245***	.191**
Regular Churchgoers	.509	.522	.199***	.265***
Black	.092	.126	.122	.058
Hispanic/Latino	.079	.043	.112	.038
Female	.578	.448**	.505	.468**
Aged 62 plus	.297	.222	.194**	.271
In Southern States	.385	.372	.321	.327
In Rust Belt States	.238	.289	.157**	.180
In Union Household	.110	.184	.212***	.141
Married or Widowed	.548	.694***	.546	.582
Above Median US Income	.304	.658***	.513***	.653***
With 4-year College Degree	.220	.237	.415***	.405***
With no Education Past HS	.543	.450***	.273***	.287***
Low-Inc., Childbearing Age Women	.207	.075***	.145	.068***
Black Childbearing Age Women	.033	.018	.050	.008**

#Distribution of issue profiles significant at $p<.05$.
*$p<.10$, **$p<.05$, ***$p<.01$ on significance tests against pro-life/pro-welfare respondents.
All figures weighted for national distribution of age, gender, race, and region.

individuals, and the other group of individuals whose attitudinal combination is not officially represented by a political party, pro-choice, anti-welfare Americans.

Though many initial expectations about the groups most likely to compose pro-life, pro-welfare Americans are confirmed, some expectations are not. First, the pro-life, pro-welfare group does not have a distinct religious or racial composition. Catholics, Blacks, and Latinos are not disproportionately represented. Pro-life, pro-welfare Americans do differ significantly in their distribution of religious denominations and their religiosity (measured as the proportion attending religious services "often" or at least once a week), but only relative to pro-choice Americans of either welfare position.

White evangelical Protestants and regular churchgoers are over-represented among pro-lifers, irrespective of their welfare views, while seculars are under-represented.[46]

As a general rule, pro-life, pro-welfare Americans look a little more like other pro-lifers than other welfare state supporters. Marital status is the only characteristic that separates pro-life, pro-welfare respondents from the rest of the pro-life population (but not both pro-choice groups). Pro-welfare pro-lifers are less likely to be married or widowed than other pro-lifers.

Gender separates pro-welfare Americans of either abortion position from Americans who do not support welfare state expansion. Women comprise nearly 60 percent of the pro-life, pro-welfare group, the largest share among the four issue combinations, but the difference from a pro-choice, pro-welfare group that is half female does not attain statistical significance. Similar results obtain when we consider the extent to which those women most likely to benefit from childbirth-supporting welfare policies participate in any pro-life, pro-welfare constituency. Since chapter five's survey showed independent effects for race as well as financial need in the likelihood that childbearing decisions were or would have been altered by economic assistance, I isolate low-income (less than U.S. median) and black women of reproductive age (adults under age 45) for further analysis. Both groups of women overwhelmingly fall into the pro-welfare category. Low-income, pro-welfare women split about evenly between pro-life and pro-choice positions. This group, however, constitutes a greater but not statistically significant share of the pro-life, pro-welfare group than the pro-choice, pro-welfare

[46] For coding of respondents' churches into religious denominations, see Layman and Hussey (2005). Note that I have coded only whites as evangelical Protestants. This is standard practice in the religion and politics literature (e.g., Layman 2001), as black churches whose denominations may technically be evangelical tend to be marked with a wholly different culture, theological perspective, and style of worship.

group, 21 percent versus 15 percent. Pro-welfare black women split nearly two-to-one in favor of a pro-choice position and make up about the same share of both issue profiles.

Age, region, and union membership distinguish pro-life, pro-welfare Americans from other welfare state supporters, although not from the other two groups. Retirement age individuals and people residing in Rust Belt states comprise a greater share of pro-life welfare state supporters than pro-choice welfare state supporters. The pro-life, pro-welfare group also contains a significantly smaller share of union households, perhaps reflecting the close association of union members with the Democratic party and hence its platform.

The only demographic characteristic that distinguishes pro-life, pro-welfare individuals from the other three groups is socioeconomic status. Pro-life, pro-welfare Americans earn smaller incomes and have attained less education. Thirty percent of the households of pro-life, pro-welfare Americans earned more than the median U.S. household income, compared to 51-66 percent of the other three groups. The proportion of pro-life, pro-welfare adherents holding four-year college degrees, 22 percent, nearly doubles when considering both groups of pro-choice Americans. The proportion that did not continue education past high school, 54 percent, far exceeds that of the other three issue profiles.

Overall, 56 percent of the pro-life, pro-welfare constituency comprises demographic groups believed to be in the process of realigning to the Republican party: white evangelical Protestants, white Catholics, and white Southerners of other religions. Of these, more than half attend church frequently. On the other hand, the degree of which these individuals might be expected to join the Republican ranks may be moderated by

their lower socioeconomic status. Some evidence does suggest a growing “income gap” in party identification and presidential voting, with lower income individuals increasingly concentrated on the Democratic side (Fiorina, Abrams, and Pope 2005).

When the relative contributions of most of these characteristics are compared in a multinomial logit model of adherence to each issue combination (Table 7.2), four demographic characteristics emerge as significant: evangelical Protestantism, church attendance, income, and education. Both religious variables continue to separate pro-life, pro-welfare Americans from both groups of pro-choicers. Income and education remain significant negative predictors of a pro-life, pro-welfare position, though education level attains significance only with respect to both pro-choice groups. Although some political scientists hold that issue attitudes or values shape partisan attachments, others suggest that sometimes this relationship works in reverse order (Carsey and Layman 2006; Goren 2005); I thus also consider party identification in this model and find significant differences between pro-life, pro-welfare Americans and the other three groups. Movement toward stronger Republican attachments is associated with a greater likelihood of belonging to either anti-welfare group, relative to the pro-life, pro-welfare position. Increasing Republican identification also significantly decreases the likelihood that someone would hold the pro-choice, pro-welfare combination rather than the pro-life, pro-welfare combination. In sum, evangelical Protestantism, church attendance, income, education, and party identification significantly predict possession of pro-life, pro-welfare beliefs rather than a combination of the pro-choice position with either welfare view. Pro-life, pro-welfare Americans stand out from other pro-lifers only by their lower incomes and more Democratic leanings.

Table 7.2 Predicting the Pro-Life, Pro-Welfare Orientation

	Vs. Pro-life/ Anti-welfare	Vs. Pro-choice/ Pro-welfare	Vs. Pro-choice/ Anti-welfare
Evangelical Protestant	.053	-.861**	-.608*
	(.311)	(.377)	(.345)
Frequent Church Attendee	.016	-1.540***	-1.298***
	(.259)	(.283)	(.281)
White	-.098	-.041	.107
	(.325)	(.300)	(.323)
South or Rust Belt	.226	-.252	-.309
	(.256)	(.251)	(.254)
Female	-.184	-.060	-.031
	(.253)	(.261)	(.259)
Age	.003	.002	.011
	(.007)	(.007)	(.007)
Education	.011	.334***	.150*
	(.086)	(.087)	(.086)
Income	.117***	.081***	.156***
	(.024)	(.022)	(.025)
Party Identification	.216***	-.296***	.107*
	(.065)	(.068)	(.065)
Constant	-2.473***	-.349	-2.864***
	(.626)	(.557)	(.636)
Likelihood Ratio χ^2 (27 df)	226.390		
Prob(χ^2)	0.000		
Pseudo R^2	0.159		
N	731		

Table presents multinomial logit coefficients (robust standard errors).
*p<.10, **p<.05, ***p<.01
Results weighted for national distribution of age, gender, race, and region.

Results from the last column of Table 7.2, in combination with the last column of Table 7.1, suggest that the demographic composition of the pro-life, pro-welfare group does not simply reflect the characteristics of the less ideologically constrained. The pro-choice, anti-welfare position also fails to fit neatly on the left-right spectrum as currently defined by the major political parties. If the lower socioeconomic status of the pro-life, pro-welfare population stems principally from a more general lack of ideological constraint, we might expect also to find a preponderance of less well-educated, perhaps lower-income citizens among those possessing the pro-choice, anti-welfare issue

combination. This is clearly not the case. Pro-choice welfare conservatives earn significantly more than their counterparts and also have completed significantly more schooling. On the combination of these indicators, they also appear to be at least as well-off as those Americans whose views more closely track the major party platforms.

Later in this chapter, I elaborate and speculate on the differences between pro-life, pro-welfare Americans and this other group of supposedly inconsistent individuals.

7.3.2 Political Behavior

I now turn to the political behavior of pro-life, pro-welfare Americans, presenting descriptive findings, considering to what extent this group's behavior is rooted in its demographic composition rather than specific to this issue profile, and providing a status report on the characteristics and relative size of that pool of individuals most likely to respond to Democratic advocacy of welfare as a pro-life issue. I consider several sets of questions:

First, is the pro-life, pro-welfare issue profile a compromise position? Is this group more conservative on welfare or less conservative on abortion and other cultural issues than the wider samples of pro-welfare and pro-life individuals? Do they place themselves at a more middling ideological position, or do they adopt a label that is inconsistent with their beliefs on one of these issues?[47]

Second, how does this group appear to resolve the conflict between the Democratic pull of the pro-welfare position and the Republican pull of the pro-life position? Is one issue more salient than the other? Does relative issue salience translate into party identification and presidential vote choice?

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[47] See Schiffer (2000) on a trend in Democrats calling themselves conservative in spite of their liberal welfare views.

Third, do we find support for the expectation that pro-life, pro-welfare Americans, by virtue of their demographic characteristics and their ideological inconsistency, lag behind the rest of the population in political awareness and political engagement? How large is the pool of pro-life, pro-welfare Americans exhibiting enough awareness to potentially receive new Democratic messages? What can we predict about this subgroup's potential for reliable Democratic support based on their current affiliations and behavior?

Table 7.3 summarizes highlights of the political characteristics of the pro-life, pro-welfare constituency and notes significant differences from other pro-life Americans, other pro-welfare Americans, and pro-choice welfare conservatives.

Individuals who combine a pro-life and pro-welfare position appear only marginally more moderate than the single-issue groups from which they come. This group's mean score on the broader welfare factor is statistically but not substantively more conservative than that of the rest of the pro-welfare group, 0.31 versus 0.27 on a 0-1 scale. On abortion, no difference exists between the percentage of pro-welfare Americans versus other pro-lifers who say that abortion should never be permitted versus those allowing exceptions for rape, incest, and the life of the mother. Not shown in the table, they do not lag far behind other pro-lifers on their strength of support for a partial-birth abortion ban. On the other hand, pro-welfare individuals (while remaining strongly opposed) are not so strongly opposed to paying for abortions with government money as the rest of the pro-life sample, and are significantly more inclined to favor funding. If abortion is considered part of a broader set of interwoven moral and cultural issues, pro-

Table 7.3 Political Behavior of Pro-life, Pro-welfare Respondents

	Pro-life/ Pro-welfare	Pro-life/ Anti-welfare	Pro-choice/ Pro-welfare	Pro-choice/ Anti-welfare
Issue Context				
Overall welfare state support (0-1)	.31	.63***	.27***	.60***
Abortion position (1-4)	1.73	1.71	3.71***	3.68***
Moral/cultural issue support (0-1)	.56	.63***	.27***	.39***
Ideology+#				
Extremely liberal	1.74	.57	8.4	.56
Liberal	5.90	2.53	24.91	6.97
Slightly liberal	12.80	3.05	17.81	11.88
Moderate	35.62	19.75	36.37	27.62
Slightly conservative	17.11	17.58	7.51	22.02
Conservative	22.62	45.57	5.01	29.14
Extremely conservative	4.20	10.95	0.00	1.81
Partisanship+#@				
Strong Democrat	17.56	5.07	27.92	10.78
Weak Democrat	14.82	10.03	16.83	8.84
Independent (Lean Democrat)	14.95	10.11	28.14	10.55
Independent	9.25	5.36	10.08	11.06
Independent (Lean Republican)	14.82	16.03	4.65	12.43
Weak Republican	14.79	15.07	9.1	19.76
Strong Republican	13.82	38.33	3.28	26.58
Issue Salience				
Health insurance salience (1-5)	1.80	1.90	1.78	2.05***
Abortion salience (1-5)	2.01	1.97	2.29***	2.40***
Percent 2-party vote for Bush				
Of total	.53	.82***	.20***	.68**
Health insurance more salient	.36	.75***	.23*	.62**
Abortion more salient	.77	.89	.20***	.58***
Equal salience	.52	.81***	.16***	.78**
Political sophistication				
Factual political knowledge (0-1)	.43	.53***	.54***	.58***
Aware of party differences on government spending	.65	.74*	.81***	.75**
Aware of party differences on abortion	.51	.69***	.71***	.66***
Ideological inconsistency (0-3.55)	1.84	1.61***	1.54***	1.85
"Very much" campaign interest	.45	.57**	.53	.58**
Media (lack of) exposure (0-1)	.44	.42	.42	.38***
Political participation (0-1)	.20	.29***	.29***	.26***

*p<.10, **p<.05, ***p<.01 on significance tests against pro-life/pro-welfare respondents.
+Distribution significantly different from pro-life/anti-welfare respondents at p<.05.
Distribution significantly different from pro-choice/pro-welfare respondents at p<.05.
@ Distribution significantly different from pro-choice/anti-welfare respondents at p<.05.
All figures weighted for national distribution of age, gender, race, and region.

welfare Americans (while still very conservative) are statistically more liberal than the rest of the pro-life population, averaging 0.56 versus 0.63 on a 0-1 scale.

Self-placement on NES's general ideology scale also indicates that pro-life, pro-welfare Americans appear to be splitting the difference between two more extreme positions. They are at once statistically more conservative than other pro-welfare Americans, while statistically more liberal than other pro-life Americans. They are significantly more likely than other pro-life Americans to call themselves moderates, but not more so than pro-choice individuals of either welfare view.

Pro-life, pro-welfare Americans find social welfare and abortion respectively just as salient as do other pro-welfare and pro-life Americans. Measuring issue salience with respondents' rating of the importance of an issue to them, and using health insurance importance to indicate social welfare salience,[48] pro-life, pro-welfare Americans also do not differ from other pro-lifers in the salience of health insurance, though they do find abortion to be more important than do pro-choice, pro-welfare Americans. Generally the two issue salience indicators increase together, with those for whom health insurance is more salient also tending to rate abortion as an important issue, and vice versa.

As with ideology, the partisan loyalties of pro-life, pro-welfare Americans are more Democratic than other pro-lifers' and more Republican than other welfare state supporters'. One-third of them identify as Democrats and 29 percent identify as Republicans, figures that increase to 47 and 44 percent if Independents leaning one way or another are treated as partisans. Despite their combination of positions on some of the most important partisan issue cleavages, pro-life, pro-welfare Americans are no more

[48] Of the four indicators that make up my pro-welfare measure, NES queried respondents only on the importance of health insurance.

likely to be independents or weak partisans than pro-choice adherents of either welfare persuasion, although their partisanship is statistically weaker than that of the rest of the pro-life sample (p=.02, not shown).

This group's presidential voting follows the same patterns as its partisan identification. Pro-life, pro-welfare respondents claiming to have gone to the polls gave the same share of the two-party vote to George W. Bush as the entire weighted NES sample. The 53 percent who punched a ticket for Bush, however, significantly exceeds that proportion of pro-choice, pro-welfare America (20 percent) but falls well below that of the rest of pro-life, anti-welfare America (82 percent).

Presidential vote choice also generally breaks as issue salience might predict. Large majorities of pro-life, pro-welfare Americans for whom social welfare issues were more salient voted for John F. Kerry, while Bush took the lion's share of votes from those for whom abortion was more salient. This suggests that Democratic messages aimed at making social welfare issues more salient could win some additional voters, especially if this group is led to believe that its votes would contribute to a second cause (reducing abortions) which otherwise appears to have tempered its enthusiasm for the pro-welfare candidate.

That said, how likely are these Americans to receive and respond to such messages? A glance at multiple measures of this group's political sophistication decreases its attractiveness for mobilization and conversion efforts. Consistent with what we might expect given their low levels of education and income, pro-life, pro-welfare respondents score well below Americans of the other issue combinations on multiple measures of political awareness and sophistication (see Appendix for construction of

these measures). Collectively, this group rates poorly on scales of factual political knowledge. It scores a 0.43 on a 0-1 scale of political figure and congressional majority recognition, a significant 0.10-0.15 points lower than the other groups' averages. As a further descriptive aid, I divide the sample into low, middle, and high awareness categories, with the cutpoints being one-third or fewer and two-thirds or fewer responses correct. The opinions of low-awareness individuals are not likely to change in response to elite messages, save for messages of the highest intensity, given these individuals' lack of exposure to political communication (Converse 1962; Zaller 1992). They are also less likely to change the weighting of political considerations in response to an issue frame, given the fewer cognitive linkages they are believed to make among political matters (Druckman and Nelson 2003; Nelson, Oxley, and Clawson 1997). Half of pro-life, pro-welfare respondents fall into this low-awareness category, compared to 30-36 percent of the other three groups. The probability of opinion change is maximized among individuals at middling levels of awareness, while susceptibility to framing effects appears to increase with political awareness. Thirteen percent of the pro-life, pro-welfare group has attained the highest level of political knowledge (versus 26-32 percent of the other three groups), leaving 37 percent in the middle awareness category.

A similar gap (not shown) exists on a scale measuring respondents' ability to place Democrats to the left of Republicans on a number of policy issues: respondents combining pro-life and pro-welfare attitudes score 0.60, while everyone else averages 0.76-0.77. Like the rest of the sample, they are better at recognizing party differences on social welfare than they are on abortion. Sixty-five percent place Democrats to the left of Republicans with regard to the balance of government spending and services, and 51

percent correctly order the parties on legal abortion. Table 7.3 notes these percentages for the other three issue profiles. Notably, pro-life, pro-welfare respondents come closer to closing the political knowledge gap on social welfare than on abortion.

Pro-life, pro-welfare respondents, relative to other pro-welfare and pro-life individuals, also exhibit significantly lower levels of overall ideological consistency. At the same time, their score on this measure nearly equals that of pro-choice, anti-welfare Americans. Here, I define ideological consistency in the terms set by the Democratic and Republican platforms and construct this measure by taking the standard deviation of respondents' self-placement (Barton and Parsons 1977) along 13 NES economic, cultural, and foreign policy issues. Thus the inconsistency with elite positions does not appear to be confined solely to the particular issues under study.

In addition to their lower levels of political knowledge and attitudinal constraint, pro-life, pro-welfare Americans profess to be less interested in the 2004 campaign and report marginally less exposure to the news media. Post-election, the gap between these individuals and Americans of the other three issue combinations expressing "very much" interest in the 2004 campaign stands at 8-13 percentage points. While maintaining the same level of exposure and attention to the national network news, pro-life, pro-welfare Americans report reading both print and online newspapers with significantly less frequency than respondents that do not combine these issue positions. They are also significantly less likely to follow campaign news in magazines, on the radio, and on television.

This relative disengagement appears characteristic of this group in particular rather than a correlate of its ideological consistency. In spite of ideological consistency

scores comparable to that of pro-life, pro-welfare respondents, pro-choice fiscal conservatives show more campaign interest and engage more frequently with the news media than do other Americans. These individuals also possess the highest levels of factual political knowledge.

Not shown in the table, individuals combining pro-life and pro-welfare positions are somewhat less likely to report being mobilized by the parties (41 percent versus 42-52 percent for everyone else). This difference, however, reaches significance only in comparison to both groups of welfare conservatives, and furthermore slightly reverses itself when considering only residents of battleground states.[49] Republicans appear to be working a little harder to reach pro-life, pro-welfare Americans, as 60 percent of those contacted by only one party were contacted by Republicans, compared to 40 percent by Democrats.

Perhaps not surprisingly, respondents with pro-life and pro-welfare attitudes report lower levels of voter turnout as well, with 71 percent claiming to have voted in 2004, compared to 82-83 percent in the three comparison groups. On every other measure of political participation, pro-life, pro-welfare respondents also report lower levels of participation. Smaller proportions of pro-life, pro-welfare Americans report trying to influence others' votes, displaying campaign buttons, stickers, or signs, and especially contributing money to candidates, parties, or others. In nearly every group-to-group comparison, the participation gap attains statistical significance at least at the .10 level. Table 7.3 compares overall participation scores across seven campaign-related activities, ordered on a 0-1 scale, and shows that pro-life, pro-welfare individuals are significantly

[49] For the two definitions of battleground states used here, see Kaufmann and Gimpel 2005. Under both definitions, at least the same proportion of pro-life, pro-welfare Americans as everyone else reports being contacted by a party.

less participatory than everyone else. Interestingly, pro-life, pro-welfare individuals participate less actively than citizens in the other three categories combined at all levels of political awareness, though the difference attains statistical significance only among middle-awareness respondents ($p<.001$).

Already having ruled out a predominant role for ideological inconsistency, given the high levels of political sophistication and engagement observed among pro-choice, anti-welfare citizens, we might next wonder how much of the lower levels of the study group's political knowledge and participation are explained by the group's demographic composition, especially its lower socioeconomic status. Table 7.4 presents the results of OLS regressions of these two dependent variables on demographic characteristics and strength of partisanship.

For political knowledge, no statistically or substantively significant gap remains between pro-life, pro-welfare individuals and each of the three comparison groups after accounting for demographics. Though every other covariate added explanatory power, education and income alone were enough to erase the knowledge gap.

The participation deficit, in contrast, resists explanation based on demographics and strength of partisanship alone (column 2). More than the lower SES of adherents, there appears to be something about holding this particular combination of ideologically inconsistent attitudes that is associated with political disengagement relative to citizens holding party-line views.

Analysis of the relative participation of that second group of respondents with a nonpartisan issue profile, pro-choice welfare conservatives, suggests that the remaining gap may reflect a combination of group-specific factors as well as a more general lack of

Table 7.4 Predicting Political Knowledge and Political Participation

	Political Knowledge	Political Participation
Pro-Life, Anti-Welfare	-.005	.048**
	(.028)	(.020)
Pro-Choice, Pro-Welfare	.009	.065***
	(.028)	(.021)
Pro-Choice, Anti-Welfare	.023	.018
	(.029)	(.021)
Education	.062***	.017***
	(.006)	(.005)
Income	.007***	.003**
	(.002)	(.001)
Age	.004***	.001
	(.001)	(.000)
Female	-.127***	-.021
	(.018)	(.014)
White	.053**	.052***
	(.022)	(.017)
South	.013	-.019
	(.020)	(.016)
Married	-.018	-.040**
	(.021)	(.017)
Union	.006	.032*
	(.024)	(.020)
Frequent Church Attendee	.031	.019
	(.021)	(.015)
Independent or Weak Partisan	-.073***	-.145***
	(.019)	(.016)
Constant	.040	.170***
	(.050)	(.038)
R^2	0.347	0.221
N	729	729

Table presents OLS coefficients (robust standard errors in parentheses). *p<.10, **p<.05, ***p<.01. Results weighted for national distribution of age, gender, race, and region.

issue alignment with a major party. Accounting for demographics does narrow the participation gap with pro-choice, anti-welfare Americans, such that it loses statistical significance. In turn, statistical differences do exist between the participation levels of these individuals and pro-choice, pro-welfare Americans, but there is no statistical difference in participation with pro-life, anti-welfare Americans, net of demographics and strength of partisanship. Plausibly, individuals whose issue positions agree with those of the major parties and thus with more of their candidates may have more incentive to

participate. Meanwhile, the experience of participation may increase exposure to two-party politics and with it, opportunities for learning or social interaction that may result in the modification of issue positions in the direction of one party's platform. This concern applies to pro-life, pro-welfare individuals and their political opposites alike. At the same time, the smaller differences between pro-choice welfare conservatives and the rest of the sample suggests that these citizens may possess additional unmeasured resources and motivations for political involvement that pro-life, welfare liberals lack. While further exploration of this point lies beyond the scope of this project, one possibility might include a voice within a party. Pro-choice, anti-welfare individuals identify in greater proportions with the Republican party than do pro-life, pro-welfare Americans (Table 7.3). Relative to Democrats, Republican elites display more heterogeneity on abortion and a greater willingness to showcase politicians with opposing abortion views (Sanbonmatsu 2004). Further, Republican elites' degree of conservatism on economic issues vis-à-vis their mass identifiers exceeds that observed with respect to cultural issues, while Democratic elites outflank their base more so on cultural than on economic issues (Shafer and Claggett 1995). As a result, pro-choice Republicans may enjoy more visibility and influence within their party than pro-life Democrats do.

I conclude the data analysis with a closer look at partisanship, voting, and issue salience among the 50 percent of pro-life, pro-welfare Americans possessing enough political awareness that they could reasonably be expected to hear a new Democratic message. Among middle awareness individuals, whose opinions are most apt to change upon encountering new information, Democrats hold a 31/25 percent advantage, 46/45 if leaners are coded as partisans. Seventy-five percent report having voted in 2004. This

group's voting was more Republican than its partisan ties, as Bush captured 58 percent of this group's major-party vote. No self-identified Republicans voted for Kerry, while Bush did benefit from Democratic defections. In spite of this Republican edge, however, social welfare remains a collectively more salient issue for this group than does abortion. A government health insurance plan outranks abortion in importance by just over a quarter of a point on a five-point scale, a larger gap than observed among their low- and high-awareness counterparts (19 and 9 points, respectively). Twenty-nine percent of this middle-awareness group correctly recognized party differences on social welfare and considered social welfare more important than abortion, compared to 19 percent that was aware of party differences on abortion and found abortion more salient.

High awareness individuals, while candidates for changes in issue importance based on framing effects, are much less likely to change their beliefs based on new information. Despite their formidable partisan and ideological filters, these individuals may be worth looking at as signs of what may be to come for the political behavior of pro-life, pro-welfare Americans. High-awareness individuals are the fastest at picking up elite cues (Zaller 1992), and may also be in a position to influence others who share their beliefs, if indeed individuals tend to look to likeminded, more informed individuals as their political discussants (Huckfeldt and Sprague 1987; Huckfeldt and Sprague 1988).

With the caveat that these observations should be interpreted very cautiously, given the small size of this subsample, the behavior of this group presents mixed signals about the direction of pro-life, pro-welfare Americans. Solely based on issue salience, perhaps this segment of the pro-life, pro-welfare sample should be the most Republican of all, since it comes to the closest to placing abortion on equal footing with social

welfare. Instead, the Democratic edge in party affiliation is 41/38, though Republicans grab a 55/45 advantage when including leaners. Sixty percent of these individuals voted for Senator Kerry in the 2004 election. Partisan realignments are said to begin with votes for the other party's candidates prior to a formal change in partisan identification (Erikson and Tedin 1981). If we suspected that pro-life, pro-welfare Americans are on a slow march toward the Republican party, the 2004 voting behavior of the group's most aware and engaged does not convincingly bear this out.

7.4 Conclusion

This chapter has studied those Americans that should respond most enthusiastically to new Democratic messages advocating welfare state expansion and pitching that expansion as an effort to reduce abortions. It finds that individuals combining opposition to legal abortion with support for social welfare programs constitute a nontrivial portion of the voting-age population and possess many demographic characteristics—most notably their low socioeconomic status—that may incline them toward Democratic candidates or at least temper the pro-Republican cues associated with their religious and regional affiliations. They lean Democratic in their partisan ties, a majority of their most informed voted Democratic in 2004, they consider social welfare issues more important than abortion, and they are more aware of party differences on social welfare than on abortion. At the same time, these individuals may prove difficult to reach and inefficient to mobilize. Half of this group does not figure to "get the memo" about any change in Democratic message, as indicated by its low level of political knowledge. Even the more knowledgeable members of this group are less likely than other Americans to participate in campaigns and elections.

Perhaps to some extent pro-life, pro-welfare Americans are a group that is waiting to be mobilized, or that has become alienated from politics given the relative void in elite leadership on their issue profile and what appears to be a dwindling number of major candidates who represent them. After all, much of this group's lower participation remains unexplained by demographics and partisanship. Further, we do not observe the same disengagement from politics among another cross-pressured and/or ideologically inconsistent public, pro-choice welfare conservatives. These Americans not only live in participation-enhancing higher socioeconomic strata, but they arguably receive more party-based elite support for their attitudinal profile.

In particular, three of this study's limitations suggest directions for future research. First, this study is naturally limited by the fact that its data capture only a snapshot in time. Analysis of panel data would give us a better sense of this group's direction. Have they been pulling back from political involvement as the parties polarize? Has the size of this group been shrinking over time, and if so, how much has been driven by individual change in issue positions relative to generational replacement? Are pro-life, pro-welfare Americans more likely to abandon one position rather than the other?

Second, the sample size and design of the present data source, the National Election Study, precludes analysis of those Americans who have arguably initiated the present partisan issue alignment, party elites and activists (Adams 1997; Carmines and Stimson 1989; Carmines and Woods 2002; Layman 2001). Perhaps a more meaningful assessment of the direction of pro-life, pro-welfare America would involve an elite study indicating how party elites came to resolve the tension between these two beliefs, and which elites changed positions on which issue. It will also be instructive to observe to

whether recent rumblings about Democrats' need to "get" religion and to reach out to pro-life, culturally conservative voters result in renewed visibility for elites who lean in a pro-life, fiscally liberal direction, such as Virginia Governor Tim Kaine and Pennsylvania Senate candidate Robert Casey, Jr. As I suggest in my analysis of political participation, the opportunity to support, or to support the party of, candidates sharing their issue positions could mobilize pro-life, pro-welfare Americans. A larger dataset than one year's NES would be needed to test this hypothesis.

Third, testing the sensitivity of Americans' welfare attitudes and Democratic support to a pro-life frame lies beyond the scope of the present project, but could be the focus of future experimental research. While abortion has undoubtedly contributed to the breakup of the New Deal coalition and the retreat of many of its members into the GOP, we also know that attitudes on abortion are extremely stable (Jelen and Wilcox 2003) and that attitudes on family values issues that might inform abortion opinion are more stable than attitudes about equal opportunity and the scope of government that might inform attitudes toward the welfare state (Goren 2005). We do not know whether that stability of belief applies to stability in issue salience, and thus whether the mass public might be persuaded to vote for pro-choice candidates aiming to accomplish pro-life objectives through social welfare means.

At present, this analysis must conclude that while a constituency may exist for expanding welfare programs, and that framing the expansion as an effort to reduce abortions may help retain or recover voters whose pro-life beliefs might otherwise tempt them to vote Republican, the electoral wisdom of doing so comes down to an efficiency judgment. Given the Republican alternative, Democrats are unlikely to lose pro-choice

votes by simply talking about reducing abortions, so long as their favored means do not involve legal limitations on reproductive choice. However, the limited return on communicating such a message, given the relative disengagement of its targets, may divert resources more effectively spent on other constituencies. Such a move also risks tempering pro-choice elites' enthusiasm for Democratic campaigns. It is possible that increased elite support for this issue combination may energize or re-energize pro-life, pro-welfare voters. But that process will take time, and its prospects are a matter for future research.

In the end, however, Democrats may have little will to change their message, or ability to deliver on it. It is not clear whether Democrats would lose existing supporters by reemphasizing social welfare liberalism after several campaigns' worth of movement toward the middle on fiscal issues. Such traditional Republican themes as welfare reform and deficit reduction were priorities of the last Democratic president, President Clinton, and Democrats' only presidential victories since the 1960s have come with centrist Southerners heading the ticket. At what was arguably the last time that Democrats attempted a major social welfare expansion—President Clinton's 1993 universal health care initiative—the effort failed miserably in spite of unified Democratic government. In order to mobilize pro-life, pro-welfare votes, it seems that Democrats would need to mount a relatively high-intensity information campaign featuring not only a new approach to abortion, but also a reversal of the rightward trend in their social welfare messages. Absent this, a pro-life, pro-welfare Republican voter may see little to gain on either issue from joining or returning to the Democratic fold.

Chapter 8: Conclusion

In this study, I set out to answer two questions. The first concerned the effectiveness of social policy and social services in reducing abortion, especially relative to a second and more popular proposed policy tool, limitations on abortion access. The second question concerned the political feasibility of approaching the abortion issue with capacity-building policy tools. Below, I summarize answers to these questions and comment on the implications of these findings for the politics and policy of abortion and social welfare.

8.1 Does Welfare Generosity Reduce Abortions?

8.1.1. Summary of Findings

My central question was, are women's economic needs and the degree to which these are met by social services decisive factors in their decisions between abortion and childbirth? Put more simply, do welfare access and welfare generosity reduce abortions? I approached this question in four different ways. Some analyses provided more support than others for the central hypotheses, that there exists a group of women whose abortion decisions are driven by economic need, and that access to more generous social welfare services decreases the likelihood of abortion among needy women.

First, I explored the state-level relationship between abortion rates and welfare policies. Results suggested that over the 1990s and late 1980s, state expansions in Medicaid eligibility, adoptions of family leave laws, and developments in child care availability, affordability, and quality contributed to modest reductions in abortion rates.

At the same time, aggregate abortion rates did not appear to be affected by cross-state and over-time differences in the program serving the poorest women, Aid to Families with Dependent Children/Temporary Assistance for Needy Families. The relationships between welfare policies and abortion rates also displayed greater sensitivity to model specification than did the relationship between this variable and alternative policy tools pertaining to abortion access. Decreases in abortion access, measured with abortion provider supply and the enforcement of laws on parental involvement and Medicaid funding of abortion, consistently predicted lower and faster falling abortion rates.

In chapter four, I looked at individual-level determinants of the abortion decision, focusing attention on the roles of economic hardship, welfare receipt, and state welfare generosity, and as well as two policy alternatives, the nongovernmental safety net and abortion access limits. Among urban, disproportionately low-income and single mothers in the Fragile Families Study, economic deprivation did predict the decision to terminate a subsequent pregnancy. At the same time, with the more welfare programs from which she received assistance, a woman's predicted likelihood of choosing abortion increased. Respondents living in states that spent more generously on social welfare were also more likely to choose abortion. Further analysis indicated that these significant positive relationships were confined to married black women and unmarried white women, respectively, and that the positive welfare effects diminished considerably when controlling for state policies through which welfare bureaucracies may directly or indirectly facilitate abortions, family caps and bans on abortion counseling by public employees. Receipt of nongovernmental assistance was statistically unrelated to abortion

decisions, while the probability of choosing abortion decreased substantially with the restrictiveness of abortion access in a respondent's state.

Chapter five offered more, but nonetheless lukewarm, support for a connection between welfare assistance and abortion decisions. Women choosing abortion in my survey of Baltimore abortion and pregnancy center clients enjoyed more economic advantages than women choosing childbirth. Though at least some of the results reported in this chapter must be attributed to biased samples, abortion patients did not appear to be objectively more disadvantaged than women choosing childbirth even when the abortion sample was truncated to place the maximum income on par with the childbirth sample's. They did, however, assign greater importance to the economic aspect of their decision than did women choosing childbirth. No respondent chose abortion solely for economic reasons, nor did any mother mention economic assistance in isolation as her reason for choosing childbirth. The large proportion of welfare recipients among the childbirth sample produced a less than believable negative relationship between welfare receipt and the decision to abort—however, even among this very low-income sample, less than a fifth of mothers indicated that they might have chosen abortion instead if they had not received certain public or private assistance. Larger proportions of abortion patients, concentrated among the most economically disadvantaged, reported that they would have or might have chosen childbirth had an array of European-style social welfare assistance been available to them. While this result supports the potential of welfare policy to reduce abortions, this potential is likely to go unrealized in the United States, where neither the major political parties nor public opinion support such an expansive welfare state.

Findings from all three chapters suggest that child care is one particularly salient barrier to choosing childbirth, and that a broad policy approach to the problem of scarce, unaffordable, and/or substandard child care could promote modest reductions in abortions. Larger proportions of Fragile Families respondents experiencing problems with their existing child care arrangement chose to terminate subsequent pregnancies. In my survey, notable proportions of respondents reported that child care issues had factored into their decision to abort or had led them to consider abortion. Additionally, child care ranked among the top resources chosen by abortion patients as necessary to support a different decision. Of all the social welfare policies considered in my state-level abortion rate study, a summary measure of a state's child care availability, affordability, quality and political commitment most strongly predicted reductions in abortion rates, over and above the existing trend.

Chapter six then took a closer look at child care availability at the neighborhood level. It considered whether the neighborhoods of poor women, whose abortion rates are disproportionately high, are under-served by the child care market. Analysis of the number of child care providers per neighborhood in 12 states offered marginal support for this hypothesis. Analysis in this chapter did not support the idea of a simultaneous tendency of abortion providers to locate themselves in disadvantaged neighborhoods. Arguably, these results could very well work out differently with the use of more advanced geographic analysis techniques, such as measures of distance from neighborhoods to providers, or richer data on child care providers, but a visual survey of the distribution of child care providers, abortion providers, and distressed neighborhoods in Maryland does not give us reason to expect opposite results.

8.1.2 Behavioral Motivations of Target Groups

With respect to this dissertation's central question, the results of these four chapters converge to tell a coherent story. The first part of the story concerns the behavioral motivations of women choosing abortion and childbirth, and in particular, the role of economic need in women's decisions. Economic need does appear to push toward abortion some women who may otherwise be ambivalent about this decision. Surely these women constitute a minority of abortion patients, albeit a sizeable one, and the pool of women turning to abortion does include high-income, highly educated women along with the financially destitute. While the abortion decision undeniably involves economic aspects, this research confirms previous work in suggesting that the decision results from a combination of individual economic and social circumstances, moral or religious beliefs, and lifestyle preferences. My survey pointed to the importance of individual religiosity, attitudes toward legal abortion, and social support for the decision to pregnancy resolution. Additionally, the statewide indicators of policy liberalism on abortion access, family planning assistance, and welfare generosity that showed up so significantly in chapters three and four probably also capture effects of the cultural context in which women make childbearing decisions, in addition to policy impact. In contrast to the assumptions of previous research, however, women's responses to my survey suggest that even if economic need is not the only reason for choosing abortion, some women would choose otherwise if only they had access to assistance addressing that need. One particular policy remedy suggested by this project has been the expansion of child care supply in poor neighborhoods, but as it turns out, even socioeconomic

disparity in this resource distribution is not so dramatic as envisioned, and will only go so far in affecting abortion incidence.

8.1.3 Evaluation of Capacity-Building Policy Tools

The second part of the story flows from my evaluation of the effectiveness of social welfare assistance as an abortion policy tool. I assume that understood as a capacity-building tool, welfare assistance reduces the need for abortion by defraying the costs of motherhood. The current American welfare state, at best, appears to have only a minimal impact on women's decisions between abortion and childbirth. Whether this minimal association favors childbearing or abortion depends on a woman's characteristics, policies in her state of residence, and the type of welfare program.

Benefits currently offered by the American welfare state, especially those offered by the more narrow cash assistance program colloquially known as "welfare," do not appear to sufficiently defray the cost of parenthood for the poorest American women. Substantial proportions of welfare recipients in the Fragile Families study and my own report objective and subjective experiences with economic hardship in spite of the benefits they receive. Baltimore abortion and pregnancy center clients also appear to perceive that the existing safety net does not meet their needs. Women in both groups reported that concerns about welfare rules, child care options, and the support available from employers or schools weighed in their decisions. Nearly a quarter of abortion patients professed that their lack of awareness about where to find help affording a child played a role in their decision, and several women in the childbirth sample also reported that they had considered abortion for this reason. Given the positive relationship observed between some welfare generosity measures and the abortion decision, I find it plausible

that the relatively paltry amount of aid provided by cash welfare and women's experience with this uniquely extensive and supervisory bureaucracy instead facilitates abortion access for those women who seek it and perhaps encourages abortion among more ambivalent women.

Results from my survey and from state-level relationships indicate that for some women, the assistance presently offered by the American welfare system does provide that decisive extra help they need in order to afford to become mothers. However, even among my sample of mothers that was heavily populated by welfare recipients, relatively few of these women indicated that they would have chosen abortion if they had not received public and private assistance. Many of these women expressed pre-existing inclinations toward motherhood and against abortion. Even though they had not been planning to have a baby, these women appeared determined to find the assistance they needed to make it work, from the pregnancy center through which they entered my sample, from public programs, and from others. If these efforts had not succeeded, most women still would not have sought an abortion.

My survey findings suggest that European-style welfare policies could substantially, though not overwhelmingly, reduce abortions. It is highly doubtful, however, that the American government would or could enact this sort of policy in the midst of public opinion, fiscal, and institutional constraints, even if the Democratic party possessed unified control over the national government.

8.1.4 Evaluation of Policy Alternatives

My results also work together toward a conclusion on the third part of my story, the evaluation of social welfare assistance relative to alternative policy tools. In this

dissertation, I considered two such alternatives, reliance upon the nongovernmental safety net and authority tools in the realm of abortion access.

Incorporated in the partisan cleavage of social welfare is a debate over the extent to which economic aid should be provided by the government rather than by families, churches, community organizations, and the private sector. Closer to the study at hand, while the pro-life movement spends little energy on public social welfare advocacy, it does fund, promote, and operate thousands of pregnancy aid centers, maternity homes, and other resources for women with problem pregnancies. Republican leaders like George W. Bush have recently brought such organizations into the public eye and have attempted to procure federal funding for their efforts. While my study did not specifically evaluate the impact of such organizations, it did consider the more general category of nongovernmental assistance available to pregnant women from private individuals and entities. Results from the Fragile Families study and my own survey suggest parallels between the role of public assistance and private assistance in abortion and childbearing decisions. The two types of aid appear to complement rather than substitute for each other. As with public assistance, private assistance was never named on its own as a very important reason for women's choice of childbirth, and was only marginally more likely than public assistance to be rated as important. In the Fragile Families study, receipt of increasing amounts of private assistance was statistically unrelated to the decision to abort.

Authority tools, as discussed in chapter two, constitute the bulk of the current approach to abortion policy. These policies pertain to the circumstances under which a legal abortion may be obtained, and are closely linked to the supply of abortion providers.

In chapters three and four, such state-level measures strongly and reliably predicted variation in aggregate as well as individual abortion behavior. A small minority of participants in my survey cited problems accessing abortion among their reasons for choosing childbirth, or reported initial difficulty in obtaining an abortion. Rather than making it impossible to obtain a legal abortion, most abortion policy measures work by creating hurdles to obtaining the procedure that—theoretically—can eventually be overcome with persistence and additional expense. While I did not investigate this, I suspect that the statistical association observed between abortion accessibility and abortion incidence reflects a largely indirect relationship, in which abortion accessibility enters a woman's assessment of the costs and benefits associated with the procedure.

8.2. Is a Welfare Approach Politically Feasible?

My secondary consideration in this policy analysis concerned the political determinants of policy tool choice. In chapter two, I considered some explanations for the lack of a serious capacity-building approach to abortion policy. These included a less than favorable social construction of abortion seekers and the lack of major-party support for the coupling of welfare liberalism with what might strike some activists as a compromise position on abortion policy. I suggested that both of these explanations were rooted in how American politics defines abortion and welfare as public issues.

In chapter seven, I proceeded to ask whether, in spite of present party platforms, a mass constituency existed for capacity-building abortion policy. I also considered whether such a constituency would be attractive enough to Democrats to justify suggestions that they change their message on abortion. This new message suggested by

political commentators would articulate a desire to reduce abortions, and would emphasize family-friendly social and economic policies as the means to that end.

Using public opinion data from the 2004 National Election Study, I identified a group of individuals combining a pro-life position on abortion with welfare policy liberalism. These individuals constituted about 20 percent of the public expressing opinions on both issues, the smallest group of the four issue combinations. In terms of elite representation, these individuals are arguably the biggest losers. While pro-choice welfare conservatives do enjoy some visibility in the Republican ranks, neither party accords much prominence to persons or policies representing the pro-life, pro-welfare position. This makes sense when considering the composition of pro-life, pro-welfare America. Such individuals fall short of other Americans in terms of income and education. They know and care less about politics, and report lower levels of participation in campaigns and elections. While Democratic outreach efforts such as attempts to reframe welfare as a pro-life issue or even to sponsor more pro-life, pro-welfare candidates may very well mobilize this group, this constituency is not likely to assert itself in party politics. It is also not clear that the Democratic party would find the high-intensity information campaign necessary to reach this resource-challenged group worth the risk and trouble.

8.3 Implications

Little mystery remains, then, as to why abortion policy has not relied more on capacity-building tools, and why a welfare-as-pro-life theme has received so little play in American politics. Even though some may argue that it is normatively superior, given its emphasis on choice and resources, a capacity-building approach does not appear to make

efficacious abortion policy. Neither do attempts to activate the pro-life, pro-welfare constituency appear to make efficacious politics. Even members of this apparently hospitable constituency, should they pick up on cues about a fresh Democratic approach to abortion policy, may hesitate to alter any Republican habits they may have developed. In addition to depending on normative considerations such as which women's decisions would be affected by which policies and whether the type of message projected by choice of policy tool is practically or symbolically important, individual pro-lifers' responses may come down to their own expectations and judgments. Specifically, these might concern the probability that Democratic power will make a big difference in the size and scope of the welfare state, and whether the expected impact of Democratic welfare policies will outweigh the expected impact of the liberalized abortion laws that Democrats also favor. Democrats' recent retreat from the welfare state suggests that the former is unrealistic, while the present research fails to place welfare policies on par with more traditional abortion policy when it comes to policy compliance.

In spite of the heretofore incomplete state of research on this topic, the current American approach to abortion policy does not seem so off the mark. Neither does the relative absence of mothers' needs and social policy shortcomings from abortion rhetoric. To the extent that some consider abortion a "problem" to reduce, it does not appear to be a problem that clamors for the type of capacity-building remedy that government could provide. Economic assistance might very well enable motherhood among individual pregnant women who express ambivalence about abortion, but such women's need for material resources is also likely entangled with a host of more personal concerns that do not lend themselves to public policy solutions. These include matters such as the

desirability of single parenthood, the response of a support network, and the consistency of abortion with a faith tradition.

In short, even if widely publicized, this research changes little about the trajectory of the policy and politics of abortion and social welfare. This empirical study of the relationship between economic disadvantage, childbearing decisions and the potentially mediating effect of social policy has offered mild support for the argument that a more expansive welfare state will reduce abortions. It offered still milder support for the argument that current welfare policies exert a "pro-life" impact on abortion incidence. Furthermore, I accompanied these findings with a heavy dose of political pessimism about the prospects for expansions in U.S. welfare policy. Absent these, we can hardly consider current welfare policy to be "capacity-building."

Though its conclusion is not exactly scintillating, this research remains important. Evidence now exists to inform policy and political arguments about the relationship between welfare and abortion. Strategists for the political parties and for pro-life and pro-choice organizations alike may also be interested in these findings. In many ways, findings affirm their present approaches to these issues. This is not to say that welfare liberals could not fruitfully employ a pro-life frame to revive support for their cause. While a test of its effectiveness must wait for future research, we can safely say for now that such a redefinition of the abortion issue would be inconsistent with women's experience and unlikely to inspire policy or partisan change.

Appendices

Appendix A. Chapter Three Data

Abortion Numbers, Rates, Ratios, and Providers: Most data were provided to the author by the Alan Guttmacher Institute, the research affiliate of the Planned Parenthood Federation of America, from its surveys of all known abortion providers. Many of these data are published regularly in the organization's journal (Finer and Henshaw 2003; Henshaw 1998a; Henshaw and Van Vort 1994). I divide each state's number of abortion providers by its population (in 100,000s). CDC abortion data are published annually in varying "surveillance summary" issues of the *Morbidity and Mortality Weekly Reports*.

Child Care: Ratings and progress reports are published in the February 1993, March 1994, March 1995, June 1996, July/August 1997, July/August 1998, July/August 1999, and November 2000 issues of *Working Mother* magazine. In 2000, *Working Mother* did not produce a 10 Best list, but continued to publish data on the factors that had previously determined the rankings. I concluded there was little reason to believe that any of the 10 Best States should be replaced, and so coded the 1999 10 Best for 2000. Recognition of states for improvement in child care were not handled uniformly over the time-series

Family Leave: Coded 0-2 for 1988-2000 and 0-1 for 1993-2000. Sources: (National Partnership for Women and Families 2002; U.S. Department of Labor 1993; Waldfogel 1999).

Medicaid Eligibility Thresholds: Data come from the National Governors' Association's Maternal and Child Health Updates, using the mid-year report if two updates were issued.

Family Cap: Coded 1 if at any point during that year a woman could conceive a child that would be excluded from benefits. Sources: (Crouse 1999; Stark and Levin-Epstein 1999; U.S. General Accounting Office 2001).

Welfare Benefits: Data prior to 1997 was provided to the author by the Department of Health and Human Services. Data for future years come from the Administration for Children and Families' annual TANF reports to Congress.

Abortion Access: Does not count statutes containing exceptions that would render the bill irrelevant. Does include laws providing for judicial bypass of parental notification or consent, and Medicaid funding bans including narrowly tailored exceptions for very specific medical circumstances. Sources: (Merz, Jackson, and Klerman 1995; National Abortion and Reproductive Rights Action League 2001; National Right to Life Committee 2001) and also numerous secondary sources for resolution of conflicts, ambiguities, or missing data.

Other controls: Data come from the SPPQ Data Archive (2003), the Census Bureau, and *Statistical Abstracts of the United States.* Income is adjusted for cost of living. SES measures load on a single principal components factor (eigenvalue=2.35).

Appendix B. Chapter Four Data

Cities included in the Fragile Families Study:

Austin, TX	Detroit, MI	New York, NY	Pittsburgh, PA
Baltimore, MD	Indianapolis, IN	Nashville, TN	Richmond, VA
Boston, MA	Jacksonville, FL	Norfolk, VA	San Antonio, TX
Chicago, IL	Milwaukee, WI	Oakland, CA	San Jose, CA
Corpus Christi, TX	Newark, NJ	Philadelphia, PA	Toledo, OH

Key Variable Definitions and Coding:

Pregnancy Outcome: Abortion=1; baby, miscarriage or stillbirth and no additional abortion= 0. Women experiencing miscarriage or stillbirth receive this code because they resemble the birth group more so than the abortion group on many key variables, and coefficient size changes little when they are removed from the sample. Over 40 percent of respondents were pregnant the time of the interview, so I assigned pregnancy outcomes using the study's third wave. If R reported a miscarriage or abortion in addition to a birth at the third wave interview, I assigned pregnancy outcome based on the third-wave ages of children and time between interviews. I coded 31 women who did not participate in the third wave with no abortion because only one of the other women's third wave responses indicated she had later terminated that pregnancy. I excluded 27 women who had reported being pregnant at the one-year interview but at the 3-year interview reported no birth, abortion, or miscarriage.

Economic need/economic hardship: Coded 1 if R reported at least one of the following because there wasn't enough money: received free food or meals; went hungry; child(ren) went hungry; did not pay full amount of rent/mortgage; evicted from home; did not pay full amount of utility bill; gas or electric turned off; telephone disconnected; borrowed money to help pay bills; moved in with others; spent at least one night in a

shelter, abandoned building, car, etc.; anyone in household did not make a needed doctor or hospital visit.

Number of welfare programs: See text. Scale ranges 0-1, mean .421, standard deviation .267.

State welfare generosity: Per capita state spending on "public welfare" in 2000, from *Statistical Abstract of the United States*. COLA-adjusted mean=662.40, standard deviation=152.68.

Private assistance received: See text. Scales ranges 0-1, mean .404, standard deviation .318.

Expected support: See text. Scales ranges 0-1, mean .628, standard deviation .302.

Abortion access: Ranges –1.03-1.42, mean 0, standard deviation 1. Provider numbers are published in Finer and Henshaw (2003) and divided by Census 2000 state population (in 100,000s). Abortion policy data come mainly from NARAL Pro-Choice America (2005; 2001). To resolve ambiguities regarding enforcement status or exceptions to the laws, National Right to Life Committee fact sheets, online news coverage, and the laws themselves were consulted.

Family planning access: See text. Scale ranges 0-1, mean 0.43, standard deviation of .282. Data on laws regarding insurance coverage for contraceptives come from NARAL Pro-Choice America (2005; 2001). Remaining family planning policy data come from a Health Systems Research survey of state officials for the Kaiser Family Foundation (Schwalberg et al. 2001).

Appendix C. Abortion Patient Questionnaire

Section 1. Your Decision and Your Resources

1. Had you been planning to get pregnant at the time of your last pregnancy?

☐ Yes ☐ No ☐ No, but I was open to it

2. When did you decide that abortion was the best decision for you?

☐ Almost immediately

☐ After I thought for awhile about my options of abortion, parenting, and adoption

☐ After some of my circumstances changed, so I couldn't continue the pregnancy after all

3. How important were the following reasons to your decision to end your pregnancy? [rotate item order]	**Very Important**	**Somewhat Important**	**Not Important**	**Doesn't Apply**
A baby would endanger my job or my career plans.	☐	☐	☐	☐
A baby would endanger my schooling or my school plans.	☐	☐	☐	☐
I cannot afford to have a baby because I struggle to afford my own and my family's basic needs.	☐	☐	☐	☐
I can afford my own and my family's basic needs, but I cannot afford to have a baby.	☐	☐	☐	☐
I do not want to be a single mother.	☐	☐	☐	☐
I have problems in my relationship with the father of the pregnancy.	☐	☐	☐	☐
I have some physical problem or problem with my health.	☐	☐	☐	☐
There was a possible problem affecting the fetus's health.	☐	☐	☐	☐

My husband, partner, parents, or the father of the pregnancy wanted me to have an abortion.	☐	☐	☐	☐
I don't want my parents or other people to know I had sex or got pregnant.	☐	☐	☐	☐
I became pregnant as a result of rape or incest.	☐	☐	☐	☐
I do not feel I am mature enough to have a(nother) child.	☐	☐	☐	☐
I already have as many children as I want or can handle.	☐	☐	☐	☐

4. Do you agree with the following statements about access to abortion and family planning services?	**Yes**	**No**	**Don't Know/ Doesn't Apply**
It was hard to find money for my abortion, so I was afraid for a while that I would have to continue the pregnancy.	☐	☐	☐
Government regulations prevented me from getting my abortion as soon as I wanted it.	☐	☐	☐
I live too far away from an abortion provider, so I was afraid for a while that I would have to continue the pregnancy.	☐	☐	☐
I visited a clinic (a false pregnancy center or false abortion clinic) that tried to talk me out of having an abortion.	☐	☐	☐
If I had been able to afford birth control, I never would have been pregnant.	☐	☐	☐
If I had known more about effective birth control, I never would have been pregnant.	☐	☐	☐

5. Could you have had access to any of the following things if you had chosen to continue your pregnancy?	**Yes**	**No**	**Don't Know/ Doesn't Apply**
Health care	☐	☐	☐
A place to live	☐	☐	☐
Child care while you work or go to school	☐	☐	☐
Supplies such as diapers, formula, clothing, and baby furniture	☐	☐	☐
Several weeks off of work after childbirth, with most of your pay	☐	☐	☐
The chance to take a break from school and come back later with no penalties such as loss of financial aid	☐	☐	☐

6. Other countries provide a lot of assistance to women and their families that the government, employers, and schools in the U.S. do not provide. These countries give women things like free child care, free health care, money they can use to pay their family's expenses, and the chance to take months or even years off of work with pay after giving birth. Would you have made a different decision about your pregnancy if you could get that kind of help?

☐ Yes ☐ No ☐ I don't know

7. If you might have decided differently, what would have been most important for government or others to provide?

☐ Health care ☐ Housing

☐ Child care ☐ Time off from work or school, with pay

☐ Money to pay for family expenses ☐ Some other help

☐ None of it. I would not have decided differently.

8. Did any of the following affect your decision to terminate your pregnancy?	**Yes**	**No**	**Don't Know/ Doesn't Apply**
Welfare rules, such as a work requirement, a time limit, a sanction?	☐	☐	☐

You didn't know where you could get help affording a child?	☐	☐	☐
Difficulty finding reliable, affordable care for your existing children?	☐	☐	☐
Your employer or school was not supportive of pregnant women and mothers?	☐	☐	☐

9. *When you found out you were pregnant*, were you receiving help from a government program such as welfare, food stamps, Medicaid, WIC, housing assistance, or child care assistance?

☐ Yes ☐ No ☐ I don't know

10. What government programs do you currently receive help from? (check all that apply)

☐ Welfare (TANF)
☐ WIC
☐ Food Stamps
☐ Housing assistance
☐ Medicaid or MCHIP
☐ Child care assistance

11. Think of all the people who are important to you. Do you think they would mostly approve or disapprove of your decision to terminate your pregnancy instead of continuing the pregnancy?

☐ Most would approve ☐ Most would disapprove ☐ About half and half

Section 2. Your Background

12. How old are you? ________ (please write the number)

13. Which best describes your employment status?

☐ Employed fulltime
☐ Not employed, but looking for work
☐ Employed parttime
☐ Not employed and not looking for work

14. Are you currently attending school?

☐ Yes, fulltime
☐ Yes, parttime
☐ No

15. What is the highest grade or year of regular school that you have completed?

☐ 8th grade or less
☐ Some high school
☐ High school diploma (completed 12th grade)
☐ G.E.D.
☐ Some college or 2-year degree
☐ Technical or trade school
☐ Bachelor's degree
☐ Graduate or professional school

16. What is your marital status?

☐ Currently married
☐ Never married
☐ Divorced or separated
☐ Widowed

17. Are you currently living with a man who is your husband or partner?

☐ Yes
☐ No

18. How many children do you care for in your home? ________ (please write the number)

19. How many of these children did you give birth to? ________ (please write the number)

20. What is your race/ethnicity?

☐ White
☐ Black
☐ Hispanic/Latina
☐ Asian
☐ American Indian (Native American)
☐ Other

21. What is your religious preference, if any? (Please write and be as specific as possible, for example, African Methodist Episcopal, Roman Catholic, Reform Jew):
____

22. About how often do you attend religious services?

☐ At least once a week ☐ A few times a year

☐ Once a month ☐ Never

23. ***Before your last pregnancy*****, would you say that on the abortion issue you were more pro-life (generally opposed legal abortion) or more pro-choice (generally favored legal abortion)? [rotate]**

☐ Pro-life ☐ Pro-choice ☐ I don't know

24. What was your total household income before taxes in the last year? Include in your household yourself and any others who live with you and help support you, such as your parents or your husband or boyfriend. Include money from jobs and public assistance programs as well as other sources such as rent, interest, or dividends.

☐ Less than $10,000	☐ $10,000-$25,000	☐ $25,001-$40,000	☐ $40,001-$55,000
☐ $55,001-$70,000	☐ $70,001-$85,000	☐ $85,001-$100,000	☐ More than $100,000

Section 3.

A second part of this study is to have detailed conversations (a "personal interview") with some of the women who have completed this questionnaire. This is to learn more about the stories behind the responses you selected. If you volunteer for this second part, you would talk with a University of Maryland graduate student. You would be paid $20 and it would probably take about 1 hour. She could arrange to meet with you at a time and place that is convenient for you. Because of specific needs of the research study, she may not need to contact everyone who volunteers for a personal interview.

☐ *No, I am not interested in the interview.*

☐ *Yes, I volunteer for the interview. My first name is ____________________. My telephone number or email address is __________________________. It (is/is not – please circle) okay to leave a message at my telephone number.*

END OF SURVEY

Thank you for your time! The researchers realize this may have been difficult for some women to complete.
Please return this form to the receptionist and you will be paid $5.

Appendix D. Pregnancy Center Client Questionnaire

Section 1. Your Decision and Your Resources

1. Had you been planning to get pregnant at the time of your last pregnancy?

☐ Yes ☐ No ☐ No, but I was open to it

2. When did you decide to have and raise your baby?

☐ Almost immediately

☐ After I thought for awhile about my options of abortion, parenting, and adoption

☐ After some of my circumstances changed, I changed my mind about having an abortion

3. How important were the following reasons to your decision to have and raise your baby? [rotate item order]	**Very Important**	**Somewhat Important**	**Not Important**	**Doesn't Apply to Me**
Being a mother is very fulfilling.	☐	☐	☐	☐
I think abortion is wrong.	☐	☐	☐	☐
Some special people in my life supported me.	☐	☐	☐	☐
I saw an ultrasound (sonogram) of my unborn baby.	☐	☐	☐	☐
I got counseling or help from this (or another) pregnancy center.	☐	☐	☐	☐
I got help affording a baby from a government program like welfare (TANF), food stamps, Medicaid, child care assistance, or housing assistance.	☐	☐	☐	☐
I got help affording a baby from family, friends, my employer, school or church, or another organization.	☐	☐	☐	☐
I wanted an abortion, but I couldn't afford it.	☐	☐	☐	☐
I wanted an abortion, but I lived too far away from a clinic.	☐	☐	☐	☐

4. Think of all the people who are important to you. Do you think they would mostly approve or disapprove of your decision to raise your baby, instead of choosing abortion?

☐ Most would approve ☐ Most would disapprove ☐ About half and half

5. ***When you found out you were pregnant*****, how important to you were the following concerns? [rotate item order]**	**Very Importa nt**	**Somewh at Importa nt**	**Not Importa nt**	**Doesn't Apply**
Having a baby would have endangered my job or my career plans.	☐	☐	☐	☐
Having a baby would have endangered my schooling or my school plans.	☐	☐	☐	☐
I could not afford to have a baby because I struggled to afford my own and my family's basic needs.	☐	☐	☐	☐
I could afford my own and my family's basic needs, but I could not afford to have a baby.	☐	☐	☐	☐
I did not want to be a single mother.	☐	☐	☐	☐
I had problems in my relationship with the baby's father.	☐	☐	☐	☐
I had some physical problem or problem with my health.	☐	☐	☐	☐
There was a possible problem affecting the fetus's health.	☐	☐	☐	☐
My husband, partner, parents, or the baby's father wanted me to have an abortion.	☐	☐	☐	☐
I didn't want my parents or other people to know I had sex or got pregnant.	☐	☐	☐	☐
I became pregnant as a result of rape or incest.	☐	☐	☐	☐
I did not feel I was mature enough to raise a(nother) child.	☐	☐	☐	☐

I already had as many children as I wanted or could handle.	☐	☐	☐	☐

6. Did any of the following make you think about having an abortion?	**Yes**	**No**	**Don't Know/ Doesn't Apply**
Welfare rules, such as a work requirement, a time limit, or a sanction?	☐	☐	☐
You didn't know where you could get help affording a child?	☐	☐	☐
Difficulty finding reliable, affordable care for your other children?	☐	☐	☐
Your employer or school was not supportive of pregnant women and mothers?	☐	☐	☐

7. *When you found out you were pregnant*, did you think you could have had access to any of the following things?	**Yes**	**No**	**Don't Know/ Doesn't Apply**
Health care	☐	☐	☐
A place to live	☐	☐	☐
Child care while you work or go to school	☐	☐	☐
Supplies such as diapers, formula, clothing, and baby furniture	☐	☐	☐
Several weeks off of work after childbirth, with most of your pay	☐	☐	☐
The chance to take a break from school and come back later with no penalties such as loss of financial aid	☐	☐	☐

8. *When you found out you were pregnant*, were you receiving help from a government program such as welfare, food stamps, Medicaid, WIC, housing assistance, or child care assistance?

☐ Yes ☐ No ☐ I don't know

9. What government programs do you currently receive help from? (check all that apply)

☐ Welfare (TANF)
☐ WIC
☐ Food Stamps
☐ Housing assistance
☐ Medicaid or MCHIP
☐ Child care assistance

10. Think about the help you got from government programs, family, friends, or others, with your expenses like baby supplies, child care, health care, housing, and time off from work or school. Do you think you would have had an abortion if you had not received this help?

☐ Yes
☐ No
☐ I don't know

11. Of all the help you received (if any) with your child-related expenses, what kind of help was most important to your decision to have your baby instead of an abortion?

☐ Health care
☐ Housing
☐ Child care
☐ Time off from work or school
☐ Baby supplies, or money to buy them
☐ Some other help
☐ None of it. I would not have considered abortion.

Section 2. Your Background

12. How old are you? ________ (please write the number)

13. Which best describes your employment status?

☐ Employed fulltime
☐ Not employed, but looking for work
☐ Employed parttime
☐ Not employed and not looking for work

14. Are you currently attending school?

☐ Yes, fulltime
☐ No
☐ Yes, parttime

15. What is the highest grade or year of regular school that you have completed?

☐ 8th grade or less

☐ Some high school

☐ High school diploma (completed 12th grade)

☐ G.E.D.

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☐ *Yes, I volunteer for the interview. My first name is ____________________. My telephone number or email address is ___________________________. It (is/is not – please circle) okay to leave a message at my telephone number.*

END OF SURVEY

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